HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE

PREPARED BY THE DEPARTMENT OF HEALTH AND SOCIAL SECURITY

VOLUME 18, NO. 9, ABSTRACTS 1264-1419. SEPTEMBER 1978

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HOSPITAL ABSTRACTS

Vol. 18 September, 1978 No. 9

HOSPITALS IN OTHER COUNTRIES

1264. L'hôpital en progrès. Fème assises nationales de l'hospitalisation publique, 12-18 Janvier 1978. **[The progress of the hospital. 7th national congress on public hospitals, 12-18 January, 1978.]** *La Revue Hospitalière de France*, Paris, 1978, March, vol. 42, no. 309, pp. 571-678.

The working parties' reports on: (i) the cost of health and the hospitals; (ii) management control and the hospital enterprises; (iii) doctors and the hospital; (iv) investment in human resources; and (v) prevention, are given here in an abbreviated form, and the lively discussions to which they gave rise at the 7th National Congress on Public Hospitals in January, 1978, are reproduced.

1265. WEGMILLER, D. C. **Multi-institutional pacts offer rural hospitals do-or-die options.** *Hospitals*, Chicago, 1978, Jan. 16, vol. 52, no. 2, pp. 51-54.

Some problems of rural hospitals in the United States are outlined, with particular reference to the pressures exerted on them by government planning guidelines. In attempts to solve these problems, rural hospitals are increasingly sharing services. There are four common types of sharing arrangements: (i) one hospital provides services to a group of small institutions; (ii) a state hospital association establishes a non-profit corporation that sells services to hospitals; (iii) an organization that operates hospitals develops a shared services programme; and (iv) a free-standing corporation develops shared services. Other multi-institutional modes include affiliation agreements, rural consortia, contract management, and multi-hospital systems. Health Central, Inc., a non-profit organization, has developed a variety of sharing programmes and other services to more than 80 hospitals in a six-state region. Benefits of multi-institutional arrangements include: savings achieved through greater volume; improved accessibility and quality of care; greater stability; political influence; and forestalling or eliminating duplication of capital and operational costs. Obstacles include: middle management opposition; competition for rural hospitals' co-operation; fear of loss of identity and autonomy by small hospitals; and excessive expectations on the part of rural hospitals.

1266. CLEMENT, J. M. Cinq ans d'investissements au Centre Hospitalier régional de Bordeaux. **[Five years of investment in the Bordeaux Regional Hospital Centre.]** *Gestions Hospitalières*, Mantes, 1978, March, no. 174, pp. 219-222.

The author outlines the hospital building programme in Bordeaux over the past eight years. A total of 1,300 beds has been provided on the Pellegrin site in the centre of the city for surgical, emergency, and maternity patients, and the renovated Saint André Hospital provides a further 651 beds. There is also the children's hospital with 410 beds; this is soon to be replaced. To the south of the city 600 beds have been provided at Haut-Levêque for medical, surgical, emergency, and cardiac patients, and to the north a new building for the University Hospital has just been

completed and a 500-bed hospital on the same site should be ready by 1980. In addition 1,400 places for student nurses, laboratory technicians, and paramedical staff have been provided in two institutes, one in the centre and one in the south. The outline is accompanied by a map and three photographs.

1267. Un 'Fontenoy' au Centre Hospitalier de Rennes. **[A 'Fontenoy' in Rennes Hospital Centre.]** *Gestions Hospitalières*, Mantes, 1978, March, no. 174, pp. 225-229.

At the beginning of the 1950's the Regional Hospital at Rennes consisted of the Hôtel Dieu and the Hospice de Pontchaillou; the latter was outside the city and was used mainly for chronic patients. A new 700-bed hospital block for Pontchaillou was planned as early as 1953 but not actually completed until 1969. With the upgrading of the hospital to University Hospital status and the expansion of the city itself, further extensions were necessary; these included a central kitchen and a data processing centre, and an emergency and poisons centre. A 530-bed Fontenoy-type hospital is now being built to the south of the city. A comparison of this new hospital with the block completed in 1969 shows how methods of construction and design have changed over the past decade.

PLANNING, DESIGN AND CONSTRUCTION

See also Abstract No. 1327

1268. DAVILA, C. El programa funcional del hospital. **[The organization of the hospital.]** *Policlinica*, Barcelona, 1978, April, no. 45, pp. 10-14, 17-18, 21, 22, 25, 27.

When a new hospital is to be built, the planning team should include representatives from the health authority, the hospital management team, and the architect. Planning is an administrative function which may be described as a continuous process of investigation, synthesis, and assessment. Investigation consists of collating relevant information on the objectives, functions, organization, staffing, and facilities of the projected institution. The architect synthesises this information in his plans and sketches, and the planning team makes its assessment on the basis of these. The author briefly examines some areas which the planning team should consider: the concept of progressive care; teaching in the hospital; the different services—out-patient, in-patient, domiciliary, emergency—which the hospital provides; and he outlines the functional and administrative structure of the institution. In two tables he suggests what the approximate area for each sector in a 500-bed university hospital and a 50-bed rural hospital might be.

HOSPITAL DESIGN

See Abstract Nos. 1268, 1352

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

See Abstract No. 1267

DESIGN OF SPECIAL HOSPITALS OR UNITS

See Abstract Nos. 1355, 1397

WARDS AND PATIENTS' ROOMS

1269. A l'Assistance Publique de Paris: la suppression des salles communes. **[In the Assistance Publique de Paris: the suppression of large wards.]** *Hôpital à Paris*, Paris, 1978, Jan./Feb., no. 43, pp. 47-50.

The main objective of the Assistance Publique's (AP) investment policy since 1970 has been the modernization of hospital departments and, in particular, the replacement of large communal wards by smaller rooms. In 1973, 39 per cent of all AP beds were in large wards; today this percentage is 18. This has been achieved mainly through construction of new blocks, generally of the industrialised type. It is hoped that of the 6,731 beds still in large wards, 4,000 will be modernised and converted, and the wards which contain the other 2,622 beds will be put to another use or demolished. A table is presented which summarizes the changes in each AP establishment and how they were financed.

ENGINEERING SERVICES

ELECTRICAL INSTALLATIONS AND EQUIPMENT

See also Abstract No. 1354

1270. MESTRE ROSSI, F. Seguridad de instalaciones eléctricas. **[Safety of electrical installations.]** *Estudio sobre Hospitales*, Barcelona, 1978, no. 88, pp. 39-68.

This is a commentary on the International Electrotechnical Committee's report on low-tension electrical installations in hospitals and premises intended for medical use. The Committee's standards relating to earthing, equivalence conductors, contact voltage, protection against residual current, transformers, individual circuits, and the use of low voltages are described. Annexes to the article include a graph illustrating the body's reaction to an electric current, diagrams of electrical installations and protective conductors in the operating theatre, and a table summarising the applications of the Committee's standards to each department in the hospital.

1271. Noodstroominstallatie in Zeister ziekenhuis: bij netuitval automatische overschakeling op stroomvoorziening door twee aggregaten: beschikbare capaciteit van 900 kVA. **[Emergency current equipment at the Zeister Hospital: in the event of a mains failure the current supply can be automatically switched over using a generator and a diesel motor with an available capacity of 900 kVA.]** *Technische Gids voor Ziekenhuis en Instelling*, Amsterdam, 1978, Feb., vol. 47, no. 1132, pp. 72-73, 75, 79.

The two automatically controlled emergency units, each with a capacity of 450 kVA, have their own control panels, and in between, a general panel for manual operation. The installation is situated in the machine room, which also houses cooling radiators, provisions for noise reduction and low tension equipment with panels for selective supply sections. The total electricity supply is divided into five sections, one being a

preferential group for theatre, lights, pumps, one lift, etc. When the main voltage drops by 15 per cent or more the units are automatically switched on and non-preferential groups switched off. After approximately six seconds one unit will reach the required tension for immediate supply of the preferential group. As soon as the second unit acquires sufficient tension the frequencies are synchronized and the generator switched on to connect and complete the supply for the remaining groups. The theatre has a separate battery which immediately registers any mains failure and switches on to cover supply during the six-minute delay. When the main supply returns, supplies are restored according to a timed programme. The total capacity needed by the 255-bed hospital is 650 kVA, so the units can cope in case of further expansion. Diesel oil is used for fuel. This paper gives a highly technical, detailed description of the process, including diagrams of layout and working process, a graph illustrating the described connection between kVA (kilo-Volt-Ampere) and kW (kilo-Watt), and four photographs.

COMMUNICATION SYSTEMS

1272. CERIER, B. Sistemas de comunicacion. **[Communication systems.]** *Policlinica*, Barcelona, 1978, April, no. 45, pp. 28-30, 33, 34.

Because of the growing demand for more, better, and faster communication, the planning of the communications systems in the hospital is now as important as that of the heating or lighting system. The author briefly outlines the principles on which good communication in the hospital is based, and provides short notes on data transmission by cable or telephone, call systems, telephones for patients, pneumatic tube systems, dictation services, and radio and television. He suggests that, if they are not connected to the emergency generator, the various communication systems should have sufficient batteries to cover a minimum period of 12 hours working at maximum load.

HEATING

1273. CASTELLA GIMENEZ, F. Gestión energética y seguridad. **[Organization of energy and safety.]** *Estudios sobre Hospitales*, Barcelona, 1978, no. 88, pp. 69-80.

During the past 10 years energy consumption in the hospital has escalated; at the same time the cost of energy has increased and its availability has decreased. Economies can best be achieved by ensuring that the various energy systems are working at maximum efficiency. This requires an energy management programme, and the author shows how to design and carry out a programme of this nature; the different stages are summarized in a table. The article ends with a brief review of the techniques now available for energy conservation—the use of solar energy, total energy, heat pumps, heat recovery from the incinerator, and the use of automatic controls.

MAINTENANCE OF BUILDINGS AND EQUIPMENT

See also Abstract No. 1280

1274. Rationellt materielunderhåll kan spara många miljoner inom sjukvårdssektorn. **[Rationalization of equipment maintenance can save many millions in the hospital sector.]** *Sjukhuset*, Göteborg, 1977, vol. 54, no. 11, pp. 553-556.

Denmark and Sweden together will be investing s.kr. 16,200 million of public money

in their health services between 1978 and 1981: much of it in electronics. The client's primary interest should not be in 'investment cost' but in 'life-time costs'. It is the task of research and development units to improve and develop plant and maintain ancillary material cover. The first technological analyses comprise: frequency of occurrence of faults; choice of components; spare parts; tolerances; robustness; consequences of faulty operation; and the ability to go on working satisfactorily. The second phase of analysis comprises: times for repair or exchange; accessibility; built-in test facilities and failure indicators; protection systems; and staffing requirements. The final phase entails detailing when, where, how, why, with what and by whom maintenance is to be carried out. Only on this basis can the correct economic choice of equipment be made. An organization is then set up to maintain the equipment and keep it in an optimum state. Sound economic foundations for purchase, running, maintenance and replacement of equipment are laid down in this way. Before the money can be saved, however, technologically competent experts must be placed on purchasing and assessment committees. The article is illustrated with five flow charts demonstrating investment costs, purchasing decision making and maintenance organization.

PIPING INSTALLATIONS

1275. HOFFMAN, M., HOFFMAN, M. A. and MOUCHOTTE, F. Gaz médicamenteux et liquides inflammables. **[Medical gases and inflammable liquids.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, April, vol. 33, no. 391, pp. 51-63.

This is a systematic guide to the complexities of French legislation on the subject of medical gases and inflammable liquids and is intended for hospital pharmacists and engineers who, within the context of this legislation, share the responsibility for these substances. The regulations vary as a function of the nature and mode of distribution of the product. Inflammable liquids are classified into those with a flash point of less than 0°C, less than 55°C, and between 55°C and 100°C. The types of containers to be used and the precautions to be observed when they are stored are specified. As regards medical gases, the author discusses the colour-coding of containers, the identification of taps and valves, modes of distribution, the storage of hydrogen and ethylene oxide, and how to identify the different gases.

EQUIPMENT, FITTINGS, FURNITURE

FLOORS AND FLOOR COVERINGS

1276. FULCI, C. L'ospedale e i pavimenti. **[The hospital and floorings.]** *Tecnica Ospedaliera*, Milano, 1978, Jan., vol. 8, no. 1, pp. 52-55.

The list of desirable features of flooring intended for hospital use is a formidable one: hard-wearing, compact, quiet, water- oil- and acid-resistant, antistatic, non-inflammable, non-slip, etc. On a visit to England the author visited Marley Floors International and he describes their range of floor coverings suitable for hospital use.

EQUIPMENT GENERALLY

See also Abstract No. 1275

1277. BOSTRÖM, U. Medicinsk teknik—en viktig del i dagens sjukvård. **[Medical technology—an important part of hospital care today.]** *Sjukhuset*, Göteborg, 1977, vol. 54, no. 11, pp. 563, 565-566.

There is a shadowy dividing line between medical technology and the general technician's area, but it is important that the chief medical technician should have a level of competence and status which will ensure his acceptance as the expert by heads of department and other decision-makers in the hospital. The tasks of the department of medical technology are: responsibility for laying down maintenance principles and routines for equipment and spares; taking charge of medico-technical equipment both within and outside the hospital; supporting medical disciplines with technological competence; assisting in the assessment and purchase of equipment; registering all equipment possessed by the hospital and providing it with operating and maintenance instructions; apportioning responsibility for maintenance of equipment between technicians, operators and suppliers; co-ordinating workshop services; ensuring an adequate level of training amongst staff; assist in the use of technical apparatus; responsibility for the safety of medical apparatus; and feeding back advice to manufacturers, buyers, users, etc. The department at Linköping Regional Hospital employs 22 people and has a temporary area of 500 m^2 (electronics workshop, gases and fluids workshop, stores and office) and a total area requirement of 1,200 m^2.

1278. HEYMANNS, H. A. Das Übermass an Technik im Krankenhaus. **[Too much technology in hospitals.]** *Österreicheische Krankenhaus Zeitung*, Wien, 1977, Nov., vol. 18, no. 11, pp. 617-621.

While agreeing that technology is essential in a hospital the author, a West German engineer, considers that sophistication has gone too far and that patients' interests are being forgotten. Among examples of costly, complicated and even unnecessary installations he cites the following: special emergency power supply to supplement stand-by installations; automatic conveyor systems (which may save a few messengers but require experts to supervise and maintain them); complicated air-conditioning systems; nurse-call systems with two-way conversation controlled from a central point, which destroy personal contact between nurse and patient; and over-sophisticated equipment in intensive care units and operating theatres. All these result from an excessive preoccupation with perfection and an unwillingness to accept personal responsibility.

MEDICAL EQUIPMENT

See also Abstract No. 1380

1279. O'BRIEN, J. F. **Hospital-designed support system offers top efficiency, accessibility.** *Hospitals*, Chicago, 1978, Feb. 1, vol. 52, no. 3, pp. 85-86, 88.

This paper describes the development of the life-support system at present in use at Mercy Hospital and Medical Center, Chicago. It incorporates the best features of all possible modular wall panel designs in a single, highly efficient, floor-to-ceiling wall

panel 4½ feet wide. Everything needed for the well-being of a patient in critical need of life support has been incorporated into the panel. It was also arranged, re-arranged, updated and streamlined to facilitate patient care procedures, so that all clutter was eliminated and the best use made of space. If and when a patient gets to an ambulatory stage while still receiving critical care, a screen can be used to cover the panel temporarily, so that the area does not look so much like a critical care hospital room. Nurses say that the panel helps them to do the best possible job in life support. A photograph of the panel is included.

ELECTRONIC EQUIPMENT

1280. DUBINI, S. and BROGI, R. La manutenzione della strumentazione bioelettronica. **[The maintenance of electronic instruments.]** *Tecnica Ospedaliera*, Milano, 1978, Jan., vol. 8, no. 1, pp. 24-30.

A complex statistical analysis was carried out on the behaviour of 1,817 instruments used for clinical monitoring in intensive care units, in order to discover what types of breakdown occurred and whether preventive maintenance in the form of early replacements of instruments or components, would be justified. The instruments were divided into four categories: those connected to the patient; the purely electronic; oscilloscopes; and recorders. It was found that relatively few instruments or components broke down while "running-in" or during their average life, suggesting that they had been correctly designed and tested, and that preventive maintenance could only be profitably applied to "short-life" components, i.e. electrodes, pens, or connecting cables. The breakdown rate could be reduced if staff were properly instructed in the use of the instruments. The results of the statistical analysis are presented in five tables.

1281. LITTLE, A. D., Inc. **Guidelines for computer-based patient monitoring systems.** [PB-250-741] Washington, National Technical Information Service, 1975, ii, 41pp.

These guidelines prepared for the National Center for Health Services Research provide a data base for decision-makers in health care in their determination of needs and requirements for patient monitoring systems and in the evaluation of the costs and benefits of system implementation. The guidelines are not intended as a substitute for careful examination of published literature on patient monitoring systems and discussions with current users, but provide a starting point for the decision-making process. The eight chapters cover: aim, introduction and background; description of computerized patient monitoring systems; determining the feasibility of patient monitoring systems; selection of a patient monitoring system; operation of a computerized monitoring system; and evaluation of system operation and further system development. A select list of 15 references is included.

STAFF GENERALLY

STAFF COMPLEMENTS

See Abstract No. 1293

RECRUITMENT

See Abstract No. 1294

CONDITIONS OF SERVICE

See Abstract No 1295

STAFF MANAGEMENT

See also Abstract No. 1310

1282. LAUTERBACHER, J. Mitbestimmung im Krankenhaus. **[Staff participation in hospital management.]** *Deutsche Krankenpflege-Zeitschrift*, Stuttgart, 1978, May, vol. 31, no. 5, pp. 243-250.

Existing West German legislation on staff participation in management is outlined and its possible application to hospitals discussed under the following heads: staff participation and structural reform in the hospital; and staff participation and hospital administration. It is proposed that existing legislation should be applied to hospitals at the different levels of decision; but general discussions cannot take place on the care of patients. Staff participation is to be recommended within a framework suitable for a hospital: it is not to be recommended if it adversely affects the patient or makes it impossible to fulfil the hospital's tasks.

1283. DUYCK, J. F. Les horaires à la carte et les horaires variables dans les hopitaux. **[Rigid and flexible hours in hospitals.]** *Gestions Hospitalières*, Mantes, 1978, Feb., no. 173, pp. 127-133.

Two flexible-hours systems are described. Under the first system the individual may choose to work from 8 a.m. to midday and then, 1 p.m. to 5 p.m., or 2 p.m. to 6 p.m., or 1.30 p.m. to 5.30 p.m.; or 8.30 a.m. to midday and 1 p.m. to 5.30 p.m.; or 1.30 p.m. to 6 p.m., or again, 9 a.m. to midday and 1 p.m. to 6 p.m. Under the second system all members of staff must be present between 7 and 11 a.m., between midday and 1 p.m., and between 2 p.m. and 2.30 p.m., but are free to make up their other hours as they wish, providing they work 40 hours in one week or 80 hours over two weeks. Under both systems timetables are arranged in advance to ensure that sufficient numbers of staff are always present. The author discusses the advantages of these schemes and recommends that they be introduced gradually.

STAFF RELATIONS

See Abstract Nos. 1282, 1296

STAFF TRAINING

See Abstract Nos. 1286, 1297-1300, 1305, 1311, 1357

SPECIAL CLASSES OF STAFF

ADMINISTRATIVE AND CLERICAL STAFF

1284. RAMBO, B. J. **Ward clerk skills.** New York & London, McGraw-Hill, 1978, x, 147pp. £3.95

This book presents a comprehensive explanation of the knowledge and skills needed by ward clerks in American hospitals. There are 14 chapters which consider: the work of the ward clerks; their work in relation to the hospital setting; medical terminology; communication responsibilities; clerical responsibilities: unit management; obtaining and maintaining services; clerical responsibilities: the medical record; admissions, transfers and discharges; transcribing doctors' orders; drug orders; laboratory test orders; diagnostic procedures/special therapies; nursing and surgical orders; and progression to unit manager. Extensive lists of tests, treatments, and types of equipment are included in each chapter.

MEDICAL STAFF

See also Abstract No. 1363

1285. CAMP, J. **The healer's art: the doctor through history.** London, Muller, 1978, 180pp. £5.95

This book is an attempt to trace the changing pattern of the doctor/patient relationship through history, from the time when healing was a mixture of magic and witchcraft up to the present day. Aspects considered include: the role of the doctor in primitive medicine; Egypt and Babylon; Ancient Greece; Rome; the East and Arabia; from the Romans to the Middle Ages in Britain, and developments up to the 20th century. There is a selected bibliography of forty-one references.

1286. MCGAGHIE, W. C. and others. **Competency-based curriculum development in medical education: an introduction.** (Public Health Papers No. 68) Geneva, WHO, 1978, 91pp. Sw.fr.-9.

The main focus in this volume is on medical education, but the difficulty of producing a book that will be of use to all 150 member states of the World Health Organization has been partially dealt with by emphasizing the process of curriculum construction rather than its content. The book is divided into five sections which consider: (i) curriculum models; (ii) identification of the elements of competence; (iii) learning for mastery; (iv) assessment of competence; and (v) preparation of teachers, students and institutions. The principles considered are not limited in their application to medical education but are believed to be of general use.

1287. DURET and COTTIN. L'association du corps médical à la gestion des hôpitaux. **[Associating medical staff with hospital management.]** *Médecine Hospitalière*, Paris, 1978, Jan./Feb., vol. 14, no. 1, pp. 28-37.

Two short papers are presented, in the first of which the author points out that the level of expenditure in the hospital depends to a large extent on the type of treatment

required by the patient. She also examines to what extent the doctor in charge of a department is responsible for deciding what the level of expenditure in his unit will be. In the second paper, the ways in which medical staff are directly involved in management, as members of different committees, and in decision-making at various levels, are described and the difficulties of applying cost/benefit analysis to the hospital situation are stressed. The author suggests that the medical staff could measure the real financial consequences of their choices if each unit had a separate budget or if the cost to the patient were broken down into charges for: (i) bed and board; (ii) admission; and (iii) separate items of treatment.

NURSING STAFF

See also Abstract Nos. 1324, 1357, 1359, 1365, 1395, 1412

1288. HENDERSON, V. **The concept of nursing.** *Journal of Advanced Nursing*, Oxford, 1978, March, vol. 3, no. 2, pp. 113-130.

The acceptance of health care as a universal human right has resulted in a variety of national, provincial, state and local systems for providing care. An international network of rapid communications makes people everywhere aware of the variety of systems and the fact that some systems show better results than their own. Traditional roles for nurses and other health professionals are in question. To meet people's needs, all categories of health staff must constantly evaluate their roles and be ready to modify them for the common good and modify the programmes that prepare them for their work. While the roles of doctors, nurses and others are, necessarily, in these rapidly changing times, in a fluid state, some health workers must provide a 24-hour service to help with their essential daily activities when they lack the strength, knowledge or will to carry them out unaided and to work towards the development of a healthy independence. This intimate and essential service is the universal element in the concept of nursing. The most successful preparation of nurses will always include whatever gives them the broadest possible understanding of humanity and the world in which we live. It will also provide an opportunity to see expert nursing care given and to have the satisfaction of seeing the care they give themselves hasten a person's recovery, help a person cope with a handicap, or die in peace when death is inevitable.

1289. LABELLE, H. **Nursing authority.** *Journal of Advanced Nursing*, Oxford, 1978, March, vol. 3, no. 2, pp. 145-154.

Four factors associated with authority are identified and applied to the field of nursing: (i) extensive knowledge of one's field, together with a good understanding of related areas; (ii) accountability; (iii) interpersonal relationships; and (iv) power. It is argued that nursing authority is a vital tool for individual nurses and for nursing collectively and that the capacity of nurses to influence is enormous if only they can develop the confidence to mobilize their own individual and collective potential.

1290. PAVLOVITCH, N. **Nursing research: a learning guide.** St Louis, C. V. Mosby, 1978, vii, 265pp. £5.55

This learning guide is designed as a supplement to help students learn the essentials of nursing research in the United States. The learning guide contains eight chapters, each covering one phase of the research process. These are: problem; literature review;

hypothesis; research methods; data collection; data analysis; findings, conclusions, recommendations and implications; and research report. Each chapter consists of seven sections. The first four sections are designed to help students study the content relevant to the topic. The final three sections of each chapter give students the opportunity to apply the knowledge obtained from the readings and to develop their ability in using that knowledge in nursing.

1291. RUBIN, R. and ERICKSON, F. **Research in clinical nursing.** *Journal of Advanced Nursing*, Oxford, 1978, March, vol. 3, no. 2, pp. 131-144.

This paper presents a tested and useful method of research in clinical nursing at the doctoral and post-doctoral levels of research skill. Field theory-based, salient variables in patients' experience are inductively arrived at from empirical data. The unitizing of data provides true numbers for measurements of relationships and change in the dependent variable. Descriptive analysis and data-based theory benefit from increased reliability. It is argued that clinical field research permits a wide choice in designs and observational tools to fit the exigencies of the patient situation under investigation. The method is particularly useful to nurses in direct nursing care situations.

1292. MILLMAN, M. L., editor. **Nursing personnel and the changing health care system.** Cambridge, Mass., Ballinger, 1978, xxiii, 287pp. £5.50

This book contains the proceedings of a conference held in Glen Cove, N.Y., 8-10 June, 1977, sponsored by the Conservation of Human Resources Project, Columbia University, to discuss the changing outlook for nursing staff in the United States. The papers are divided into four sections: (i) economic perspectives and health manpower policy; (ii) supply, demand and use; (iii) conference proceedings, summary of discussion; and (iv) conclusion—policy directions. A list of contributors and participants is included together with details of the editor.

1293. MEYER, D. **Work load management system ensures stable nurse-patient ratio.** *Hospitals*, Chicago, 1978, March 1, vol. 52, no. 5, pp. 81-82, 84-85.

This paper describes a system of nursing work load measurement and management developed by a group of researchers at Grace Hospital, Morganton, N.C. The system considers all patient variables and permits a determination of the amount of care each patient should receive each day, that is, the nursing work load each day. One hour of required patient care is defined as one patient care unit. Each patient's care is assessed in PCUs on admission and each day the patient is in hospital. Patients are admitted to the units that have the lowest PCU count, the goal being an even distribution of work load among nursing units. Activities used in calculation of the PCUs were: diet, toilet, cleanliness, vital signs, turning and assisted activities, medications, suctioning, and respiratory aids. The method used in the calculation is described. The application of the system is explained and the results derived from it are discussed.

1294. SHERIDAN, J. E. and VREDENBURGH, D. J. **Usefulness of leadership behavior and social power variables in predicting job tension, performance, and turnover of nursing employees.** *Journal of Applied Psychology*, Washington, 1978, Feb., vol. 63, no. 1, pp. 89-95.

Using a sample of 216 nurses from a metropolitan hospital, this study investigated the relationships of head nurses' leadership behaviour and social power variables to

staff members' job tension, performance and turnover. A regression model explained significant portions of variance in these criterion variables. Leader consideration was inversely associated with tension and terminations, but also with job performance. Initiating structure had a positive relationship with terminations. Social power variables, particularly reward and expert power, were useful in predicting job tension. The subordinates' personality attribute of locus of control did not appear to moderate any relationships, but task structure had a significant interactive effect with expert and coercive power in predicting terminations. A comparison of these findings with other predictive models indicates the need to examine a comprehensive set of predictor variables in analysing these criterion variables.

1295. A l'Assistance Publique de Paris: la situation du personnel infirmier. **[In the Assistance Publique de Paris: the condition of the nursing staff.]** *Hôpital à Paris*, Paris, 1978, Jan./Feb., no. 43, pp. 59-62.

Since 1962 there has been an increase of 41 per cent in the numbers of ward sisters and staff nurses employed in Assistance Publique (AP) hospitals, an increase of 67 per cent in the number of registered nurses, and an increase of 117 per cent in the number of theatre assistants; all this in spite of the chronic shortage of hospital staff throughout France. From a table which summarises the average annual numbers of new appointments and resignations it can be seen that, although the numbers increased overall, there were many resignations, particularly among registered nurses. The reasons given included: the wish to be nearer home; husband's transfer; difficulties in finding accommodation; poor transport; poor pay; and the restrictions of hospital life. The AP has countered with better pay; reduced and more flexible hours; better holidays; and by providing accommodation and transport. Four tables of relevant statistics accompany this account.

1296. DIMMOCK, S. and MERCER, G. **The membership of trade unions and professional associations in general nursing.** *Health and Social Service Journal*, London, 1978, April 28, vol. 88, no. 4589, pp. F25-F28.

As part of a research project into labour turnover in nursing in 1975, information was collected on membership of professional associations and trade unions by means of a questionnaire which was completed by 1,044 state registered nurses and 368 state enrolled nurses. A majority of respondents (61 per cent) were members of a collective organization; about a quarter belonged to a trade union, while the remainder were almost equally divided between members of a professional association and those who belonged to no organization. Non-members were basically younger, part-time and female. The professional associations contained a disproportionate number of women, senior ward staff and full-timers, while the unions were over-represented with men, enrolled nurses and older staff. Despite the claims which have been made only a small minority of the respondents were members of more than one organization.

1297. HIGGS, Z. R. **Expectations and perceptions of the curricular leadership role of administrators of nursing education units.** *Nursing Research*, New York, 1978, Jan./Feb., vol. 27, no. 1, pp. 57-63.

The major purpose of this study was to determine how the opinions of chief administrative officers and selected faculty members compared on their expectations and perceptions of the curricular leadership role of the chief administrative officers of

baccalaureate nursing education units. The secondary purpose was to determine the relationship between selected demographic and organizational variables and faculty opinions. The study used the comparative survey method of descriptive research, using mailed questionnaires to a national sample of deans and selected faculty members. The responses of 52 deans and 451 faculty members were analysed for intra- and inter-position consensus. Although both groups agreed that deans should be involved to some degree in curricular design and evaluation questions, there was no agreement within either group in regard to curriculum implementation questions. There was little agreement among faculty as to their conception of the dean's role. Generally, deans expected and perceived themselves as having greater involvement in curriculum decisions than faculty. The larger and more complex the nursing education unit, the less were deans perceived as being involved in curriculum decisions.

1298. LEININGER, M. **Changing foci in American nursing education: primary and transcultural nursing care.** *Journal of Advanced Nursing*, Oxford, 1978, March, vol. 3, no. 2, pp. 155-166.

Some changes which have taken place in nursing education in the United States are identified and two major movements are discussed: transcultural nursing and primary care nursing. Transcultural nursing is defined as the learned, scientific and humanistic subfield of nursing which focuses upon the comparative study and analysis of different cultures and subcultures in the world, with respect to caring and nursing care behaviours of people and their health-illness practices, beliefs and values, with the goal of providing culture-specific and culture-universal nursing care practices. Both movements are considered to be exciting, challenging and promising developments to advance nursing education and practice. They are placing new and heavy responsibilities on nurse educators. It is argued that both transcultural nursing and primary care nursing movements need to be part of local, national and international health education and care systems.

1299. La formation du personnel dans les hôpitaux de Paris. **[Staff training in hospitals in Paris.]** *Hôpital à Paris*, Paris, 1978, Jan./Feb., no. 43, pp. 53-56.

The Assistance Publique (AP) has continued its efforts with regard to staff training, and priority has been given to the establishment of new training schools and also to in-service training. Five years ago there were 4,754 students in 26 schools for nurses, technicians, nursing administrators, operating theatre assistants, physiotherapists, radiographers, social workers, and nursing aides; at present there are 10,689 students in training, and a further 10,000 members of staff have had some form of in-service training. There are now 60,000 nursing and other qualified staff in AP hospitals as compared with 53,000 five years ago. The AP has been operating a policy of recruiting its students locally rather than from all parts of France, with the result that more now stay on when they have completed their studies. The total cost of training amounted to over 264 million francs in 1976; 28 million francs were recovered in the form of subsidies from the Ministry of Health and Social Security.

1300. CARNEVALI, O. and others. Programma—piano di studio per infermieri professionali. **[Programme-study plan for professional nurses.]** *Ospedale*, Torino, 1978, Jan./Feb., vol. 31, nos. 1-2, pp. 7-26.

A study plan programme for student nurses is described. It is intended to cover

39 weeks' study per year, for three years, or a total of approximately 4,000 hours. The programme is divided into three parts: (i) Observations, experience, and practice; (ii) Man: vital functions, needs in health and in sickness; health measures; and (iii) Health: aspects and problems for man; environment; society. Each part is subdivided into a series of problems of increasing complexity; these problems are listed.

1301. DIVINCENTI, M. **Administering nursing service,** 2nd edition. Boston, Mass., Little, Brown & Co., 1977, xviii, 467pp. £8.25

This book discusses the principles of administering a nursing service and the management needed to implement the principles. The text is in five parts. Part I presents an overview of trends in the delivery of health care. Part II considers the organization of a hospital and how the nursing department relates to the whole. Part III discusses managerial tools required to improve the administration of the nursing service. Part IV considers the physical environment, and Part V considers the human environment in which the nursing service must work. Lists of references are given at the end of each part, and there are 25 appendices covering topics such as a patient's bill of rights, samples of budgets, peer review guidelines, education programmes, nursing care plans, and nursing research.

1302. MAAS, M. and JACOX, A. K. **Guidelines for nurse autonomy/patient welfare.** New York, Appleton-Century-Crofts, 1977, xiv, 352pp. £8.05

This book describes the activities of a group of registered nurses who are engaged in increasing their authority and accountability as employed professionals in the United States. The practices developed at the Iowa Veterans Home are outlined. The book is divided into four sections dealing with: (i) nurses as aspiring professionals; (ii) the pursuit of autonomy; (iii) the impact of nurse autonomy on others; and (iv) the significance of the nurse's activities for the profession. Three appendices are included covering: study design and methods; tables of organization; and registered nurse group documents.

1303. LILLIS, L. and WAGNER, R. M. **Nursing education: its effect upon attitudes toward the mentally retarded.** *Rehabilitation Literature*, Chicago, 1977, Nov./Dec., vol. 38, nos. 11/12, pp. 358-363.

Student nurses at different course stages at three types of nursing schools in Missouri and Illinois were questioned about their attitude to, and preparation for work with, the mentally handicapped. Attitudes to treatment varied among students on different courses. Only five per cent of the total said they would prefer to work with the mentally handicapped and 33 per cent said their course did not prepare them for such work. These results show that the nursing schools did not provide adequate contact with the mentally handicapped or sufficient preparation for working with them. Nursing instructors on all types of courses should make more effort to assign students to retarded people as part of their clinical experience.

1304. CRUM, M. R. and ROWLANDS, E. E. **Open-mindedness, rigidity, and the tendency to change inferences among psychiatric nursing staff: a pilot study.** *Nursing Research*, New York, 1978, Jan./Feb., vol. 27, no. 1, pp. 42-47.

The Dogmatism Scale, Form E, and the Gough-Sanford Rigidity Scale were

presented to 120 psychiatric nurses to test the relationship between open- and closed-mindedness and between rigidity and non-rigidity, and their tendency to alter inferences when given additional information about a patient. Low-dogmatic subjects changed their inferences regarding patient behaviour significantly more than high-dogmatic subjects. Although high-rigid subjects changed their inferences about patient behaviour more than low-rigid subjects, the relationship was not significant.

1305. KECK, G. Auswahlkriterien für die Aufnahme in Krankenpflegeschulen. **[Selection criteria for admission to nursing schools.]** *Krankenhaus Umschau*, Kulmbach, 1978, Feb., vol. 47, no. 2, pp. 101-103.

The criteria for selecting student nurses which have been adopted at the district hospitals of Heidenheim and Giengen are described. They are as follows: motivation; general appearance; school record; other judgments; attitude to the school and to learning; interests and hobbies; age over 17 (older applicants are preferred); personal impression. Under each head applicants are assessed in four grades: a—considerably under expectation; b—below average; c—average and d—above average. The criteria used for grading are set out.

ORGANIZATION AND ADMINISTRATION

See also Abstract Nos. 1265, 1287, 1301, 1348, 1364, 1372, 1376, 1384, 1388, 1405

1306. CIUCCHI, G. Il livello di gestione dei servizi ospedalieri. **[The level of management of hospital services.]** *Ospedali d'Italia*, Roma, 1978, Jan., vol. 15, no. 1, pp. 32-35.

In an opening address to a working party on waste in hospital management, the author suggests that they should first ask themselves whether the benefits obtained from the hospital are, or are not related to the costs incurred. They should then consider how to measure how much waste occurs, what methods to use, at what level they should seek to identify sources of waste, whether management can be rationalised, and how to verify the validity of any solutions which they might put forward.

1307. GIANOTTI, N. Organizzazione a livello di sistema. **[Organization at system level in the hospital service.]** *Ospedali d'Italia*, Roma, 1978, Jan., vol. 15, no. 1, pp. 26-31.

Addressing a working party about to study the causes of waste in the hospital, the author recommends that they examine the subject under three headings: (i) at the institutional level (the division of responsibility for prevention, rehabilitation, and cure; the imbalance in the distribution of resources between these; the absence of regional controls; fragmentation in the allocation of funds; lack of co-ordination); (ii) at the functional-organizational level (the increasing indebtedness of the hospitals and their consequent lack of investment; the reduplication of facilities, the absence of information systems; staffing levels; staff qualifications; overspending on pharmaceutical products); and (iii) at the procedural and accounting level (the inadequacy of accounting procedures, the absence of analytical accounting, and the cumbersome methods employed for the transfer of funds.)

1308. GEBHARD, W. Leitungsprobleme des Krankenhauses. **[Problems in hospital administration.]** *Krankenhaus Umschau*, Kulmbach, 1978, Feb., vol. 47, no. 2, pp. 81-86.

The problems of hospital management are discussed under the following heads: the hospital as a managerial unit; decision levels in the hospital; the organization and management of the hospital; and participation in hospital decision-making. The decision-making powers of hospital management should be strengthened. A trend towards bureaucracy should be countered by a reasonable sharing of responsibility between hospital authorities and hospital management. The Federal Government and the *Länder* should not seek to limit the rights of hospitals: on the other hand hospitals have to bear in mind important aspects of national economy. While all necessary regard must be paid to managerial techniques it must be remembered that a hospital is not merely a public service undertaking the care of the sick: it is a place where human relationships are important and the patient comes first.

1309. HILDEBRAND, R. R. Projektmanagement im Krankenhaus. **[Project management in the hospital.]** *Krankenhaus Umschau*, Kulmbach, 1978, Feb., vol. 47, no. 2, pp. 87-92.

The basic procedures and sequences in the design and carrying out of a formal project are described, using as an example the introduction of commercial accounting systems to hospitals as required by recent West German legislation. The stages of such a project are: formulating the task; developing the concept; developing the procedure; installing the new procedure; and evaluation after a period of use. The paper also includes a section on project organization and one on planning and control (including the structure plan, the time schedule, planning for staffing, materials and costs). The paper is illustrated with a number of diagrams.

1310. PENCE, C. and KUNSA, M. **Management structure review results in program consolidation.** *Hospitals*, Chicago, 1978, March 1, vol. 52, no. 5, pp. 58-61.

Outside pressures create a need for reappraisal of hospitals' management structures and decision-making processes relative to resource allocation. To meet this challenge, the University of California Medical Center, San Diego, planned the consolidation of existing management programmes, with additional emphasis on management planning. This paper describes a new programme—the activity index—that served as the impetus in merging the hospital's goal planning process with its budget planning process. The administrative team developed and implemented an initial activity index of all areas of the hospital. Information on services offered to patients, to the community, and to the school of medicine, and on interaction between departments, was identified and documented. These were then discussed with departments. Department heads and associated directors received copies of their areas' indexes. A master file maintained by the project co-ordinator was grouped into six categories: administrative support services; ambulatory services; operational services; medical departments; nursing; and professional services. After one year's successful operation, the activity index project was merged with the management by objectives and budget planning processes into one management planning programme. Individual packets were prepared for each budget centre and for each associate to use in the programme.

1311. ERVIK, A. Utdanning i helse- og sykehusadministrasjon ved Norges Kommunal- og Sosialskole. **[Training in health service and hospital administration at the Norwegian Municipal and Social School.]** *Sykehuset*, Oslo, 1978, vol. 41, no. 1, pp. 22-25.

In 1970 a select committee estimated that there were some 1,000 administrative grade posts in the Norwegian health service whose current or potential future staff needed training in administrative techniques; some had medical, legal or economics degrees, and others had no formal qualifications at all. The committee recommended the establishment of a three-year university level course at the Norwegian College of Public Authority and Social Affairs (*Norges Kommunal—og Sosialskole*), and this was put into effect in 1974. The first two years of training comprise basic courses in legal subjects, politics and administration, institutional, national and municipal economics, and other central administrative disciplines. There is a four-month practical course at a hospital or relevant institution at the end of the second year. The third year is devoted to specialization on health sector administration. The course, of 12 hours' lectures a week, comprises 190 lectures in the organization of the health service at all levels; 90 lectures on personnel management and labour law; 30 lectures on institutional sociology; 70 lectures on hospital economics, budgeting and planning, and 60 lectures on effectiveness and computers in the health sector. The College staff of 40 was extended by four lecturers to accommodate the intake of 25 a year. When financial resources are available, lecturers will be released to regional courses, so that students do not need to take one or three years' leave to attend the course in Oslo. There are currently about 80 applicants a year for the 25 places on the course.

1312. MAGNON, R. L'hôpital est-il au service du malade ou le malade est-il au service de l'hôpital? **[Is the aim of the hospital to serve the patient or the patient to serve the hospital?]** *Gestion Hospitalières*, Mantes, 1978, Feb., no. 173, pp. 159-166.

Is the hospital run for the benefit of the patient or does the latter exist for the benefit of the hospital? In other words, is the sociological balance within the ward created for the benefit of the staff or for the good of the patient? The author examines the sociological and psychological implications of this question. He suggests that both patients and staff have technical, relational, socio-economic, and educational needs, some of which, for some patients and some staff, can be satisfied at the collective level, and some at the individual level, and he indicates in broad terms how some at least of these needs can be met.

ECONOMICS OF HOSPITAL MANAGEMENT

See also Abstract Nos. 1273, 1333

1313. CIUCCHI, G. Il fenomeno dell'espansione della spesa ospedaliera e i possibli rimedi. **[The phenomenon of the expansion of hospital expenditure and possible economies.]** *Tecnica & Metodologia Economale*, Firenze, 1978, Jan./Feb., vol. 17, no. 1, pp. 22-24.

The author suggests that the health service should be paid for out of general taxation since the employer's contribution increases his production costs and must have an inflationary effect. He also recommends that there should be a greater flow of information and closer contact between government, which allocates funds for the hospital

service, and the individual hospital which exceeds its allocation, borrows on the money market, and is not called upon to justify its actions.

1314. ZANETTI, M. Riduzione delle spese ospedaliere consoderazioni in merito alla possibilità. **[Reduction of hospital expenditure.]** *Tecnica & Metodologia Economale*, Firenze, 1978, Jan./Feb., vol. 17, no. 1, pp. 25-27.

Using mathematical and statistical techniques, the author analyzed accounting data from hospitals in the Emilia-Romagna Region to determine the relationship in each hospital between expenditure and the number of (i) out-patient consultations; (ii) radiographic examinations; (iii) instrumental examinations; (iv) laboratory tests; and (v) the average number of patients in each ward. He found that, at least for 1974, no regular relationship between services supplied and expenditure could be observed, but that the greater the number of beds, the higher the cost per bed, a plateau being reached at 200 beds. There was a correlation between the cost per bed and the productivity index (the percentage of beds occupied multiplied by 30 and divided by the average length of stay). He suggests that economies be sought in the areas of staffing and of diagnostic testing.

1315. HAUSCHILD, E. Kosten-Nutzen-Untersuchung als Entscheidungshilfe bei Investitions-massnahmen im Krankenhaus. **[Cost-benefit analysis as an aid to decision making on investment measures in hospitals.]** *Krankenhaus Umschau*, Kulmbach, 1978, Feb., vol. 47, no. 2, pp. 93-96.

Without attempting a detailed account of cost-benefit analysis this paper aims to show that if properly used in the hospital it is a useful instrument for improving the use of resources and for increasing efficiency. Cost-benefit analysis can be used either for assessing an individual measure (e.g. the introduction of a personal call system) or for studying alternative measures (e.g. whether to renovate or rebuild a ward block). Five steps are outlined: (i) an exact definition of the problem; (ii) laying down the criteria by which the measures to be assessed; (iii) testing whether the measure and the objectives are compatible; (iv) determining the benefits and costs of selected alternatives; and (v) determining the costs and benefits which, by changing their values, can effect the total result.

BED OCCUPANCY, ECONOMIC USE OF BEDS

See also Abstract Nos. 1356, 1389

1316. SWAIN, R. W., KILPATRICK, K. E. and MARSH, J. J. **Implementation of a model for census prediction and control.** *Health Services Research*, Chicago, 1977, vol. 12, no. 4, pp. 380-395.

A model is described which allows a number of possibilities for hospital census prediction or census control or both. The expected census at midnight on any one day is calculated for that, and any number of days following, by adding together the current number of patients, elective admissions during these days, and expected unscheduled admissions. The calculation is subject to a constraint on the probability that occupancy will exceed the beds available. The model can provide a detailed prediction of census in units as small as 10 beds, or can produce the recommended number of total elective

admissions to any one hospital. The model has been in use since 1975 at the Ohio State University Hospital, where it is integrated with the admission, discharge and transfer system. Census preduction can have many uses, and the model must be designed to meet the needs of the individual hospital.

1317. WILLEMAIN, T. R. **A model for certification of need for long-term care beds.** *Health Services Research*, Chicago, 1977, vol. 12, no. 4, pp. 396-406.

A model relating supply and use of long-term beds is presented within the context of matching services and need. The model aims to assess need from: (i) the existing bed supply; (ii) the percentage of the population using beds appropriately; and (iii) the quality of screening for need. The system was applied to data on supply and use of beds in skilled nursing facilities in Massachusetts. The results suggest that: (i) higher levels of bed supply are associated with higher levels of need; and (ii) varying levels of supply in different regions reflect a real variation in need.

ELECTRONIC DATA PROCESSING

See also Abstract Nos. 1281, 1325, 1373, 1406

1318. SCHMITZ, H. H. and DREBES, C. **Five keys to effective management of hospital data processing.** *Hospital Progress*, St. Louis, M.O., 1978, Jan., vol. 59, no. 1, pp. 73-76.

This paper discusses five elements that have contributed to the overall successful operation of the data processing department at Deaconess Hospital, St. Louis: (i) recruiting and retaining qualified staff; (ii) management style; (iii) the department's relationship to the total organization; (iv) independence from vendors; and (v) the personality orientation of the organization.

1319. OLLER FERRER-VIDAL, L. Los ordenadores en el medio hospitalario. **[Computers in hospitals.]** *Policlinica*, Barcelona, 1978, Feb./March, no. 44, pp. 24-27, 29.

A small computer was installed in the Neurophysiology Department of the Nuestra Señora del Mar Hospital for the analysis of ECG and EMG signals and programs were then developed so that the computer could be used in other departments. The clinical records of all patients are now held in a data bank. In particular, the clinical histories of 3,000 patients suffering from epilepsy have been coded and classified and these have yielded useful results from the points of view of the diagnosis, prognosis, course, and treatment of epilepsy. To illustrate his account the author reproduces two computer printouts, two histograms, and a record card relating to epilepsy patients.

1320. SOFFER, S. and others. **Archival storage of clinical laboratory data.** *Clinical Chemistry*, Winston-Salem, 1978, March, vol. 24, no. 3, pp. 436-441.

This paper describes the data base system for the maintenance of cumulative clinical laboratory data developed in the University of Wisconsin Hospitals. The host computer in the system is a Univac-1110 (a 36-bit/word machine) operating under Exec-8. Most

of the modules comprising the system are written in Univac assembly language. The system can dynamically transfer itself from a two-level ARCHIVAL to a three-level ACTIVE data-base system in order to optimize retrieval time. The relative advantages of these two types of data-base structure are discussed and examples of their use in clinical research are presented.

LIBRARIES

See also Abstract No. 1367

1321. SWERTZ, P. Literaturinformationssysteme für das Gesundheitswesen. **[Literature information systems for the health services.]** *Veska*, Aarau, 1977, Sept., vol. 41, no. 9, pp. 411-420; Oct., vol. 41, no. 10, pp. 473-481; Nov., vol. 41, no. 11, pp. 526-533; Dec., vol. 41, no. 12, pp. 624-629, 1978, Jan., vol. 42, no. 1, pp. 30-40.

This detailed analysis of bibliographical services in the fields of medicine and health (including hospital literature) is in seven parts: (i) introductory remarks on the importance of bibliographical services; (ii) the principles of bibliographical services (not reproduced in this paper); (iii) bibliographical services in the health field in West Germany and East Germany; (iv) documentation services in other countries; (v) present ideas on the development of an integrated documentation system (not reproduced in this paper); (vi) thoughts on the construction of an integrated bibliographical service in the field of health; and (vii) list of references (not included in this paper).

ORGANIZATION AND METHODS, WORK STUDY

See Abstract No. 1390

MEDICAL RECORDS

See also Abstract Nos. 1319, 1320, 1383

1322. SCHWEIZERISCHE AKADEMIE DER MEDIZINISCHEN WISSENSCHAFTEN. Erfassung und Auswertung von medizinischen Daten. **[The collection and evaluation of medical data.]** *Veska*, Aarau, 1977, Oct., vol. 41, no. 10, pp. 451-458; Nov., no. 11, pp. 513-517; Dec., no. 12, pp. 614-624; 1978, Jan., vol. 42, no. 1, pp. 22-29.

This is the report of a Committee on the Collection and Evaluation of Medical Data set up in January 1974 by the Swiss Academy of Medical Sciences. Its terms of reference included: the quantitative and qualitative analysis of medical data from hospitals; analysis of the need and treatment of medical data, in particular for university hospitals; health statistics; epidemiology and medical ecology; preventive medicine; Cantonal health planning and social insurance; the study of automatic processing of medical data; possible national or supra-national sources of information; and the development

of such resources from hospital information systems. Among the Committee's conclusions are the following: data collection should always have concrete aims in view; frequent contact with other medical data processing centres, to avoid duplication of effort, is important; more attention should be paid to training in medical information work; a special expert association in this field should be set up.

1323. MOSTLER, D. Das Kärntner Landeskrankenanstalten-Information ssystem—erste Ausbaustufe. **[The Carinthia regional hospitals information system—first steps in development.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1977, Dec., vol. 18, no. 12, pp. 709-712, 715.

In 1974 Klagenfurt Hospital was the first hospital in the Austrian province of Carinthia to join the hospital electronic data processing system which is based on the Carinthian Province Computer Centre. The hospitals at Villach and Wolfsberg were linked to the system in 1976. The first phase of what is called the Carinthia Hospitals Information System covers patient admissions, medical records, and accounting. Details are given of the equipment used. Further systems to be incorporated later include: multiphasic bookkeeping; national uniform cost accounting system; special hospitals; out-patient services; and pharmacy.

1324. RIEDER, K. A. and WOOD, M. J. **Problem-orientation: an experimental study to test its heuristic value.** *Nursing Research*, New York, 1978, Jan./Feb., vol. 27, no. 1, pp. 25-29.

Problem-Oriented Medical Information System (PROMIS) enables physicians, nurses and others who administer patient care to focus their attention on specific patient problems and to deal with them in a systematic way. Using a two-group before and after experimental design, this study explored the effect of problem-orientation on a nursing staff's ability to identify underlying patient problems. Nursing service staff from two small naval hospitals were instructed on problem-orientation through a six-hour workshop on the problem-oriented record, after which the system was instituted in the experimental setting. After a five-month period, tests were carried out to determine if change had occurred. Analysis of the data supported the hypothesis that problem-oreintation does, in fact, substantially increase a nursing staff's ability to identify patient problems. The incorporation of the system into nursing services could provide a vehicle for pin-pointing underlying patient problems and dealing with them in a systematic way, thereby upgrading patient care.

1325. COLLEN, M. F. **Multiphasic health testing services.** New York & London, Wiley, 1978, xvii, 668pp. £18.75

This book summarizes 25 years experience of multiphasic screening (i.e. the combination of tests for many different diseases in one package) at the Kaiser-Permanente Medical Center in Oakland, California. There are 20 chapters by different contributors covering the objectives of HMTS, and the planning, implementation and technology of the system. Separate chapters cover health education as an adjunct of HMTS and aspects such as mental health, the treatment of children, effects on patients, and research applications. Lists of references are given at the end of each chapter.

LEGAL ASPECTS OF HOSPITAL ADMINISTRATION

See also Abstract Nos. 1360, 1361

1326. ANDRÉS COROMINAS, D. Las responsabilidades juridicas de la institución hospitalaria. **[Legal responsibilities of the hospital.]** *Estudios sobre Hospitales*, Barcelona, 1978, no. 88, pp. 119-143.

This is a review of the legal responsibilities of the hospital considered as an enterprise, an institution and an organization within the context of Spanish legislation. The rights of the user, i.e. the patient, and his corresponding duties are described, and the hospital's own responsiblities and those which derive from the actions and omissions of its employees are examined with regard to both the civil and the penal codes.

OTHER SPECIAL ASPECTS—MOVING

1327. HANLON, M. E. **Hospital follows two-phase plan for move into new building.** *Hospitals*, Chicago, 1978, March 1, vol. 52, no. 5, pp. 69-72.

During August 1976, San Francisco General Hospital moved 80 hospital units, 24,000 pieces of furniture and equipment, 2,100 staff and 300 patients safely and efficiently into new buildings. On the recommendations of a consultant, it was decided to form a central team under the direction of the consultant to manage the broad activities of the move. However, department heads were still responsible for the managerial and systems changes that were necessary to make their departments function in their new locations. A two-phase strategy was decided upon: (i) a group of 'emergency' services (emergency, surgery, recovery room, four intensive care units, part of radiology and several smaller support services) were moved in a brief concentrated effort at night or in the early morning; and (ii) concurrently with, but separately from this, the rest of the hospital's services were moved during the day.

FINANCE AND ACCOUNTING

FINANCE

See also Abstract Nos. 1313-1315

1328. CASA ARUTA, D. E. Necesidad del seguro en el complejo hospitalario. **[The need for hospital insurance.]** *Estudios sobre Hospitales*, Barcelona, 1978, no. 88, pp. 145-160.

A schematic review is presented of: (i) fire insurance; (ii) insurance against theft; (iii) insurance against damage caused or accidents occurring during construction work; (iv) insurance against damage to machinery; (v) insurance for radio-active installations; (vi) personal insurance against accident or death; (vii) insurance against loss of income as a result of fire; and (viii) insurance to cover the hospital's responsibility for the acts or omissions of its employees.

SUPPLIES AND STORES

PURCHASING

1329. FAMERY, P. Politique des achats des établissements hospitaliers publics. **[Purchasing policy in public hospitals.]** *Gestions Hospitalières*, Mantes, 1978, Feb., no. 173, pp. 135-138, 141-142.

Purchasing policy has been neglected in the public hospital in France for a variety of historical and structural reasons which the author examines. He recommends that the hospital adopt a positive attitude towards purchasing policy and emphasizes the economic benefits which will accrue, particularly if the purchasing officers are well-trained, well-informed, and closely involved in general decision-making.

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

1330. MORRISON, L. P. and VADEN, A. G. **Purchasing practices in small hospitals.** *Hospitals*, Chicago, 1978, Feb. 1, vol. 52, no. 3, pp. 94-98.

A questionnaire on the use of convenience foods, purchasing practices and related management activities was sent to a stratified random sample of 300 hospitals with 100-beds or less in the West North Central region of the United States (50 per cent of such hospitals). The questionnaire was completed by 73 per cent of the hospitals. Analysis of the results indicates that because each hospital represents a unique combination of characteristics regarding size, location, food service management, philosophy, financial resources, physical resources and sources of supplies, each food service operation should analyse its own particular situation. Considerations in decisions to increase the use of convenience foods or convert to a total convenience system were: a menu meeting the needs of the institution; regular availability, nutritive value and good flavour and texture of convenience food products; reaction of staff to new products or systems; cost of additional equipment and storage space; the storage and equipment capacities of the hospital; and a portion cost comparison between convenience foods and conventional preparation. According to the study the major limitations to increased purchase of convenience foods were lack of freezer space and high costs.

1331. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. CATERING AND DIETETICS BRANCH. **Standard recipes.** (Manual of Health Service Catering vol. 3) London, DHSS, Catering and Dietetics Branch 1978, 363pp.

This volume of the Health Service Catering Manual provides a broad spectrum of 629 good quality recipes for the use of professional caterers. Ingredients, methods and nutritional values for protein, fat and carbohydrate are included. The scope of the recipes is greater than the variety generally used from day to day in most hospitals,

but it is hoped that some may be used to improve the choice available in some places and particularly to improve cyclic menus from time to time, as they tend to become stereotyped.

1332. Het menupatroon per consumentengroep wordt vastgelegd welke maaltijden worden aangeboden: 'draaiboek' voor de organisatie. **[The menus and dietary patterns are the basis for a catering organization manual: meals are provided for consumer groups.]** *Voeding- en Huishoudgids*, Amsterdam, 1978, May 1, vol. 45, no. 454, pp. 238-239, 241, 243.

The paper refers to a previous article by the NOT-team on food distribution patterns designed for meals as presented to consumer groups (patients, staff, visitors, etc.). A similar pattern, also for consumer groups, could be worked out for the component dishes which make up these meals. This would also include design of menu plans, menu cards, advice on diets, etc. with a standard design for all participating institutions. Three examples with reference to the institutions are described. The first, a warm, midday hospital meal for different groups in different places, is broken down into various component dishes. The second is designed for eight types of meals for various consumer groups at staggered times and in different places in a centre for the elderly. The third suggests a menu pattern for all meals in a centre for the elderly for different consumer groups, indicating the meal components by numbers laid down in a separate list.

FOOD SERVICE

1333. INVREA, G. and ROSATI, B. Aspetti tecnici ed economici della distribuzione del vitto in contenitori monouso. **[Technical and economic aspects of the distribution of food in single-use containers.]** *Tecnica & Metodologia Economale*, Firenze, 1978, Jan./Feb., vol. 17, no. 1, pp. 3, 5-8.

Faced with the need to renovate one kitchen and to renew all its stainless steel containers and cooking equipment and, in the meantime, with the problem of how to carry meals to patients in pavilions some distance from the second kitchen in the main hospital block, the authorities at the San Martino Hospital in Genoa solved all their problems by preparing individual portions, sealing them in disposable aluminium dishes, and keeping them hot while on their way to the pavilions by packing them in light expanded polystyrene containers which each held 24 meals. The scheme has been so successful that the old kitchen will not be needed again. The savings achieved in terms of running costs alone have amounted to 435 million lire in one year.

LAUNDRIES AND LINEN SERVICE

HOSPITAL LINEN AND TEXTILES

See also Abstract Nos. 1335, 1347, 1350, 1353

1334. CASINI, V. I tessuti-non-tessuti negli ospedali e nelle comunità. **[Non-woven textiles in hospitals and in the community.]** *Tecnica & Metodologia Economale*, Firenze, 1978, Jan./Feb., vol. 17, no. 1, pp. 45-47.

In this article the author briefly describes the process by which non-woven fabrics

are manufactured. While recognizing that these fabrics cannot replace conventional textiles in the hospital overnight, he suggests that they will be of immense value, especially in the operating theatre, in wards where infection is present, in paediatric units, and when there is a breakdown in the supply of conventional linen.

HOSPITAL DOMESTIC MANAGEMENT

DOMESTIC WORK

See Abstract No. 1345

HYGIENE IN THE HOSPITAL

1335. MAGLIULO, E. La contaminazione microbica della biancheria problema per l'igiene ospedaliera. **[Microbial contamination of laundry—a problem for hospital hygiene.]** *Tecnia & Metodologia Economale*, Firenze, 1978, Jan./Feb., vol. 17, no. 1, pp. 48-50.

The general problem of microbial infection in the hospital laundry is reviewed and some preventive measures are suggested. Immediately after use linen should be placed in a suitable bag or sack and washed before being removed. Preliminary disinfection before laundering is best, although disinfection may be carried out during the washing cycle if the rinsing water can be disposed of safely. Material is less likely to become recontaminated after laundering if it is stored in a room where the flow of air is directed outwards rather than inwards. Laundry staff should be checked regularly to ensure that they are not carriers of infective agents (Staphylococci, Salmonella, and hepatitis virus B in particular). Disinfection, disinfestation, and de-ratting of the laundry premises should be carried out regularly. Most important of all, the procedures in every hospital laundry should be standardized and rationalized.

HOSPITAL INFECTIONS

1336. SPENGLER, R. F., GREENOUGH, W. B. and STOLLEY, P. D. **A descriptive study of nosocomial bacteremias at the Johns Hopkins Hospital, 1968-1974.** *Johns Hopkins Medical Journal*, Baltimore, 1978, March, vol. 42, no. 3, pp. 77-84.

Patient, infection and pathogen characteristics are analysed for 935 cases of hospital bacteraemia at the Johns Hopkins Hospital between 1968 to 1974. The overall rate was 4.1 per 1,000 patients. Roughly six per cent of all hospital deaths were among patients with hospital-acquired bacteraemia. The case fatality rate for the seven years was 37.1 per cent, compared with an overall hospital mortality rate of 2.7 deaths per 100 hospital patients. Both the case fatality and overall hospital mortality rates declined significantly over the period. There were significant increases in Gram-positive, *Bacteroides species* and *Escherichia Coli* bacteraemias and significant decreases in *Candida species* and *Klebsiella species* bacteraemias. The hospital-acquired bacteraemia

attack rate was high for infants under one year of age, excluding newborns. The rates were low for young adults but increased markedly with age in adults older than 40. The cardiac surgery service had the highest rate of 12.4 cases per 1,000 patients. Patients with infective diseases, neoplasms, digestive diseases, diseases of early infancy or circulatory diseases had a much greater risk of acquiring bacteraemias. Of the 935 cases, 9.5 per cent had multiple episodes of bacteraemia.

1337. BERNANDER, S. and others. **Prevalence of hospital-associated infections in five Swedish hospitals in November 1975.** *Scandinavian Journal of Infectious Diseases*, Stockholm, 1978, vol. 10, no. 1, pp. 66-70.

A total of 4,246 patients in five Swedish hospitals and clinics were studied on November 4th 1975 to ascertain the prevalence of hospital-associated infections. The overall rate was 17 per cent with 11 per cent in acute disease clinics and 59 per cent in chronic disease clinics. The highest rate (72 per cent) was found in intensive care units. Fifty per cent of all infections were of the urinary tract, 25 per cent in acute cases were wound infections, and in chronic cases 20 per cent were skin infections. This study was large enough to be compared with similar ones elsewhere, but the different rates between the hospitals should be interpreted with care. More exact methods are required to evaluate the seriousness of the infections and the methods of control used.

1338. CASEWELL, M. W. and PHILLIPS, I. **Epidemiological patterns of klebsiella colonization and infection in an intensive care ward.** *Journal of Hygiene*, London, 1978, April, vol. 80, no. 2, pp. 295-300.

Twenty-four per cent of 2,315 patients admitted to the intensive care unit of St. Thomas' Hospital in the four-year period from November 1969 became colonized or infected with *Klebsiella species*. Capsular typing of 986 Klebsiella isolates from 551 patients showed that there were 695 patient-isolates, mostly derived from the respiratory tract. Capsular types 47 and 21 were the commonest types and together accounted for 19.9 per cent of the patient isloates. The 14 most common types accounted for 47.3 per cent of all patient-isolates and all these strains showed clustering, strongly suggesting a changing common source, cross-infection, or both.

1339. BRITT, M. R., SCHLEUPNER, C. J. and MATSUMIYA, S. **Severity of underlying disease as a predictor of nosocomial infection: utility in the control of nosocomial infection.** *Journal of the American Medical Association*, Chicago, 1978, March 13, vol. 239, no. 11, pp. 1047-1051.

A prospective study of hospital infection on the 120-bed medical service at Salt Lake City VA Hospital was conducted in two phases: (i) a period of 10 months during which baseline infection rates were established; and (ii) a period of eight months between June 1975 and February 1976, during which an awareness programme was instituted. The rates established in the first phase were 23.6 per cent in patients with fatal underlying disease, 9.6 per cent in those with ultimately fatal disease, and 2.1 per cent in those with non-fatal disease. After the awareness programme, which promoted the use of established methods of infection prevention, there was a decline in the overall incidence of endemic hospital infections from 9.2 to 4.8 per cent within an eight-month

period. When the programme was discontinued, the infection rate rose to 8.1 per cent. Reinstitution of the programme resulted in a decline to 5.2 per cent.

1340. SPIERS, A. S. D. **Antibacterial sink helps combat nosocomial infection.** *Hospitals*, Chicago, 1978, Jan. 16, vol. 52, no. 2, pp. 87-89.

Contamination of some equipment by Pseudomonas has been decreased by the use of disposable equipment. However, the occurrence of gram-negative bacteria in sinks and in water supplies remains a significant problem. During the planning and construction of a new unit for the intensive care of patients with leukaemia, special steps were taken to combat this problem. Thirteen special sinks were installed—one in each patient room and each anteroom and one in the ward corridor. They were constructed of stainless steel without welds or joints and plugs were not provided for the outlets. The traps were of stainless steel and incorporated a heating element with a thermostat that maintaine the water in the waste-trap at 70°C. A photograph of a sinkd is included. During the five years that the 13 sinks have been in use, there has been only one instance of isolation of bacteria (gram-negative or gram-positive) from them.

SOURCES OF INFECTION

See also Abstract Nos. 1338, 1347

1341. HAMBRAEUS, A., BENGTSSON, S. and LAURELL, G. **Bacterial contamination in a modern operating suite. 3. Importance of floor contamination as a source of airborne bacteria.** *Journal of Hygiene*, London, 1978, April, vol. 80, no. 2, pp. 169-174.

The redispersal rate for bacteria-carrying particles from a contaminated floor was determined after mopping, blowing and walking activity. Walking gave the highest redispersal factor, 3.5×10-3m-l, which was three times higher than for blowing and seventeen times higher than for mopping. The mean die-away rate for the bacteria-carrying particles used was 1.9/h without ventilation and 14.3/h with ventilation. It was calculated that in the operating rooms less than 15 per cent of the bacteria found in the air were redispersed floor bacteria.

1342. JANZEN, J. and others. **Epidemiology of hepatitis B surface antigen [HBsAg] and antibody to HBsAg in hospital personnel.** *Journal of Infectious Diseases*, Chicago, 1978, March, vol. 137, no. 3, pp. 261-265.

The sera from 3,770 employees of the Medical School of Hanover, West Germany, was tested for hepatitis B surface antigen (HBsAg) and its corresponding antibody. An average prevalence of 22 per cent for HBsAg and 11.7 per cent for anti-HBs was found. Physicians (18.2 per cent), nurses (20.1 per cent) and cleaning staff (26.3 per cent) were most frequently infected. Nurses showed a significantly higher rate of infection than a matched control group with less exposure to infectious materials. The frequency of HBsAg or anti-HBs was highest in members of staff associated with dialysis, anaesthesia, opthalmology, neurosurgery and surgery and in those who had been nursing patients with hepatitis. Strict adherence to hygienic conditions can minimize the transmission of HBV in hospitals.

PREVENTION AND CONTROL

See also Abstract Nos. 1339-1341, 1408

1343. BERGMAN, B. Ultraviolett ljus—ett alternativ till operationsboxar? **[Ultraviolet rays—an alternative to the clean air operating theatre?]** *Sjukhuset*, Göteborg, 1978, vol. 55, no. 2, pp. 86-87, 90-91.

Most cases of post-operative infection originate with the theatre personnel. Between 1936 and 1968, Hart, and his successors in Durham (Sharp et al.) developed a system of disinfecting operating room air by bactericidal ultraviolet radiation. Westinghouse Lamp Division have developed a 70 cm. long, 26 W ultraviolet tube with a life of from 4,000 to 5,000 hours and with 90 per cent of its output in the bactericidal 2,537 Angström range (Westinghouse Sterile Lamp WL-782-L30). Theatre staff require protection for their skin and eyes; and extractor equipment and air conditioning are required, amongst other things to keep the relative humidity below 50 per cent. Shaw et al. claim that the provision of sterile air in operating theatres is irrelevant to most general surgery. The introduction of operating boxes at an initial cost of s.kr. 100,000 and annual running costs of kr. 600 for energy, kr. 40,000 for materials and kr. 20,000 in capital costs has reduced the frequency of occurrence of infection following pure orthopaedic operations. Surgical isolator bags constitute another viable alternative. The most expensive Charnley box costs less than the expense to the community of two or three infected total prostheses. The article is illustrated with four diagrams; there are 34 references, 29 in English.

1344. WEINSTEIN, R. and MALLISON, G. F. **The role of the microbiology laboratory in surveillance and control of nosocomial infections.** *American Journal of Clinical Pathology*, Chicago, 1978, Feb., vol. 69, no. 2, pp. 130-136.

The microbiology laboratory's rapid and consistent identification of hospital pathogens is a keystone in the surveillance and control of hospital-acquired infections. The laboratory also serves as a source of expert consultation for clinicians and infection control staff and as an 'early warning centre' for infection problems. In order to make its contributions to infection control most effective, the laboratory must: (i) recognize its capabilities and limitations; (ii) ensure that the materials and methods it uses and the specimens it processes meet high standards; (iii) provide retrievable records; and (iv) have a good working knowledge of microbiological techniques used to evaluate both endemic and epidemic infections. Moreover, because laboratory staff come into contact daily with potentially infectious specimens and isolates, the laboratory's contributions to infection control should also include the prevention and surveillance of laboratory-acquired infections. A list of 71 references to the literature is included.

1345. Flächendesinfektion in Krankenhaus. **[Surface disinfection in the hospital.]** *Krankenhaus*, Stuttgart, 1977, Oct., vol. 69, no. 10, pp. 378-403.

This is a series of 11 papers on surface disinfection in hospitals presented at a meeting held in the University of Bonn in June 1977. Various aspects of the subject were dealt with by manufacturers, scientists and users. The titles of the papers are as follows: the control of disinfection; the development of resistance to disinfectants; the effect of disinfectants in virus diseases; development trends in surface disinfectants;

automatic dosage equipment; problems in the measuring of disinfectants for surface disinfection; safety problems in spraying alcohol disinfectants; disinfection in baths and hydrotherapy departments; combining surface disinfection with cleaning and maintenance measures; the organization of surface disinfection; and important aspects of disinfection in intensive medicine.

HYGIENE IN THE OPERATING THEATRE

See also Abstract No. 1350

1346. Les impératifs de l'hygiène dans l'aménagement du quartier opératoire. **[The importance of hygiene in the organization of the operating department.]** *Hôpital Belge*, Bruxelles, 1978, Jan./Feb., no. 131, pp. 5-23.

The author examines in some detail a series of mainly architectural innovations which have been introduced over the past few years in order to reduce bacterial pollution of the air in the operating block, to improve the quality of the care team's work, and to forestall hospital infection in the 'protected zone'. He shows why the creation of protected zones has been necessary and describes the various 'customs posts' which have been devised to enable patients, staff, and material to cross from one zone to another. He explains why the air in the operating block should be free of bacteria and discusses methods of air conditioning and ventilation, the different types of laminar flow systems, the Charnley tent, the Weber cell, the Allander ceiling, and the surgical bubble. He reviews British, Swedish, German, and Rémoise designs for the layout of the theatre block and, in conclusion, stresses the importance of observing the basic rules of hygiene and the dangers of over-use of antibiotics. His article includes 19 good diagrams and sketches.

1347. HAMBRAEUS, A., BENGTSSON, S. and LAURELL, G. **Bacterial contamination in a modern operating suite. 4. Bacterial contamination of clothes worn in the suite.** *Journal of Hygiene*, London, 1978, April, vol. 80, no. 2, pp. 175-181.

Clean clothes in the staff dressing rooms were heavily contaminated with bacteria, mainly *Bacillus species*, but *Staphyloccus aureus* was found on 14 per cent and *Clostridium species* on 10 per cent of the garments examined. A comparison of the occurrence of *Staph. aureus* on shirts worn by staff in wards and operating departments showed ward shirts to be contaminated more heavily and with more strains. Examination of sterile gowns worn by surgeons showed that 70 per cent were contaminated with *Staph. aureus* after operations. Of the strains isolated 31 per cent were identical with those carried by the surgeon or by the patient operated on, but for the remainder no source could be found.

STERILIZATION

1348. MORANDINI, M. and SALVADOR, P. Sterilizzazione ospedaliera. **[Hospital sterilization: approach for systems and methods of analysis.]** *Tecnica Ospedaliera*, Milano, 1978, Jan., vol. 8, no. 1, pp. 44-51.

A copiously illustrated (15 figures) description of the Tra.S.car modular system for centralized sterilization in the hospital is presented. The components of the system, the Tra.S.car trolleys, transport and distribution, and specific systems for theatre instruments are described.

1349. SCHROEDER, R. E. **Quality control procedures improve sterilization process.** *Hospitals*, Chicago, 1978, Jan. 16, vol. 52, no. 2, pp. 77-78, 80, 82.

When control of the central processing and distribution department at the 290-bed St. Luke's Memorial Hospital, Racine, Wis., was transferred to the director of pharmacy, one of the first priorities was to achieve high quality control standards. This paper describes the development of quality control system, which has three main features: (i) individual testing of each sterilizer load using a numbering and record-keeping system for each sterilizer; (ii) quarantining for 72 hours of all items except instruments; and (iii) placing steam-sterilized, double-wrapped muslin packs in sterile, heat-sealed plastic bags to prolong their shelf-life. The procedure followed in the new system is outlined and some problems are mentioned. The cost of the system has been balanced by greater efficiency, though the greatest importance is attached to the ability to guarantee sterility.

AIR HYGIENE

See also Abstract No. 1343

1350. MITCHELL, N. J., EVANS, D. S. and KERR, A. **Reduction of skin bacteria in theatre air with comfortable, non-woven disposable clothing for operating-theatre staff.** *British Medical Journal*, London, 1978, March 18, vol. i, pp. 696-698.

Conventional loose-weave cotton operating garments were compared with clothing of a non-woven fabric to test their efficacy in reducing the dispersal of skin bacteria into the air in the operating theatre. When men wore operating suits made of the non-woven fabric, dispersal of skin bacteria was reduced by 72 per cent. The lowest levels of contamination of the air occurred when both unscrubbed and scrubbed theatre staff wore clothes of the non-woven fabric. Although not designed for hard wear, the fabric showed no deterioration in its ability to keep down air contamination, was blood-proof, and caused no discomfort to the wearer.

SAFETY MEASURES

See Abstract No. 1270

ELECTRICAL ACCIDENTS

See Abstract No. 1270

ACCIDENTS IN GAS AND DRUG ADMINISTRATION

See Abstract No. 1376

FIRES AND FIRE PREVENTION

1351. KEATING, J. P. and LOFTUS, E. F. **Vocal emergency alarms in hospitals and nursing facilities: practice and potential.** (NBS-GCR-77-102) Washington, National Bureau of Standards, 1977, vi, 29pp.

The aim of this report is to evaluate the use of public address and other voice

communication systems in nursing homes and hospitals in the United States. The report recommends guidelines for the development of alarm messages to provide an effective response by staff to fires. A series of seven guidelines are provided for the use of hospital administrators or others composing emergency messages. A list of thirty references and two appendices presenting the results of two surveys on fire safety in hospitals and nursing homes are included.

1352. GILI, J. Aspectos arquitectonicos de la seguridad contra incendios. **[Architectual features for fire safety.]** *Estudios sobre Hospitales*, Barcelona, 1978, no. 88, pp. 81-117.

The author examines features of hospital design and construction in relation to fire prevention and detection and the evacuation of patients in the event of fire, under the following headings: (i) doors, emergency exits, and windows; (ii) passages; (iii) staircases and fire escapes; (iv) lifts and waste disposal shafts; and (v) fire compartments or fire sectors. He is opposed to the installation of revolving doors or automatic doors activated by a photo-electric cell, and to curtain walls made entirely of glass. His recommendations include a minimum length of 25/30 metres for corridors, with direct ventilation of these if possible; access to staircases through halls with fireproof doors; fire-resistant lift shafts; and an emergency power supply for all lifts. Waste disposal shafts are a common source of fires. Each floor should have a fire-resistant sector, and departments with a high fire-risk should be isolated. The author discusses the choice of construction materials and the article ends with 10 pages of instructive diagrams and 10 pages of extracts from a manual on fire protection installations.

1353. GABRIEL, S. **The struggle to overcome hazards involving textiles.** *Health & Social Service Journal*, London, 1978, March 17, vol. 88, no. 4582, pp. 314-316.

Textiles which are flame retardant are not always suitable for hospital use on grounds of comfort, cost and the necessity for constant laundering. Flame-resistant properties of textiles held in a vertical position may be measured by a test laid down in BS 5438, and include: (i) ease of ignition; (ii) flame spread; and (iii) speed of flame spread. The most important item in preventing ignition of the bed is the counterpane, which should be made from a fire retardant fibre, or finished with a fire retardant finish, of which Proban and Pyrovate are suitable. Advice on the fire hazards of textiles is contained in the Department of Health and Social Security's 'Red Book, Fire Risks Associated with Furniture, Furnishing and Textiles'.

1354. WOOLLISCROFT, M. **How electronics play an important role.** *Health & Social Service Journal*, London, 1978, March 17, vol. 88, no. 4582, pp. 316-317.

The fires at Shelton and Coldharbour Hospitals in 1968 and 1972 have led to a considerable growth of automatic fire detection systems in hospitals. The fire alarm system of a large hospital is zoned and incorporates automatic smoke detectors, heat detectors and electromagnetic door detentes. Solid state switching is replacing relay boxes and two-tone electronic sounders are replacing bells. Attention must always be paid to the power supply. Fire alarm systems may soon be incorporated into plant monitoring or computer systems, but, however sophisticated, they must always be considered as part of the overall fire plan for the hospital.

PLANNING FOR MASS EMERGENCIES

See Abstract No. 1271

RADIATION HAZARDS

1355. Establecimientos de medicina nuclear. **[Nuclear medicine establishments: their architecture, maintenance and equipment.]** *Policlinica*, Barcelona, 1978, Feb./March, no. 44, pp. 10-14, 17-18, 21-23.

This is an account of the WHO specialist committee's recommendations on the establishment of departments or centres of nuclear medicine. They suggest that the provision of these facilities should be closely linked to the provision of other specialist facilities, and a Category A (university or teaching) hospital will have a radio-pharmaceutical and chemical laboratory, where substances with high gamma activity can be handled, a separate chemical laboratory for substances with an activity of less than one milicurie and for *in vitro* tests, a room for the oral and parenteral administration of radio-active material for diagnostic purposes, and one for treatment. The minimum area of the department will be 1,200 square metres. One-storey buildings are recommended because of the weight of the equipment and protective shielding. As well as experienced doctors, nurses and technicians, the staff will include medical physicists, a radio-pharmacologist, and a radiochemist. Equipment will be required for the measurement of samples *in vitro*, for *in vivo* studies with and without dynamic visualization, and monitoring apparatus for purposes of safety will be needed. This account is illustrated by nine photographs of equipment.

THE PATIENT

ADMISSION AND RECEPTION

See also Abstract No. 1316

1356. BARBER, R. W. **A unified model for scheduling elective admissions.** *Health Services Research*, Chicago, 1977, vol. 12, no. 4, pp. 407-415.

A model is described which: (i) handles random requests for admission and the subsequent adjustment of scheduling; and (ii) provides a long-term use for hospital patient census. It can be used both for continuous admission scheduling or for periodic static scheduling. Although the census model is straightforward, a computer is needed for the complicated calculations, and to allow scheduling to be up-dated as often as twice daily.

WELFARE OF THE PATIENT

See also 1302, 1360, 1371, 1385, 1391, 1399, 1417

1357. SIERRA-FRANCO, M. H. **Therapeutic communication in nursing.** New York & London, McGraw-Hill, 1978, xiv, 402pp. £7.45

This book is organized in two sections; the first deals with the factors that affect communication and the second section considers the techniques of therapeutic

communication. Specific educational objectives are indicated for each chapter. The chapters are arranged for self-instructional use as a programmed text, presenting information in a logical sequence. There are four parts to the book: (i) introduction to therapeutic communication and the relationship; (ii) factors that affect therapeutic communication; (iii) communication techniques; and (iv) clues and the importance of timing. An appendix includes an index to chapter summaries; exercises and discussion topics and selected references.

1358. FLINN, D. E., SLAWSON, P. F. and SCHWARTZ, D. **Staff response to suicide of hospitalized psychiatric patients.** *Hospital and Community Psychiatry*, Washington, 1978, Feb., vol. 29, no. 2, pp. 122-127.

Seven case histories of in-patients who committed suicide over a five-year period are outlined. Staff reaction and the changes in policy and procedures that followed are analyzed. It is concluded that staff feelings of guilt and failure brought about by in-patient suicides may result in the implementation of procedures designed to decrease risk, but that such procedures would not necessarily have prevented the suicide that led to their introduction. It is maintained that staff acceptance of responsibility for preventing suicide may achieve short-term safety at the expense of increased long-term risk, and that suicides can occur even when all reasonable precautions have been taken.

1359. ROBERTS, S. L. **Behavioral concepts and nursing throughout the life span.** Englewood Cliffs, N.J., Prentice-Hall, 1978, xii, 301pp. £6.30

This book covers the most frequently used behavioural concepts as applied to all age groups linked with the author's belief in the importance of the humanistic approach to health care. It considers the major types of behaviour present in hospitalized people, the systems theory and its application to nursing practice. Behaviour patterns discussed include: anxiety; pain; sensory deprivation; stress; powerlessness; loss; hopelessness; hostility and anger; space and territoriality; loneliness and body images. An author and subject index are included.

VOLUNTARY SERVICE, VOLUNTARY WORKERS

See Abstract No. 1366

HOSPITAL SOCIAL WORK

See also Abstract No. 1365

1360. FOSTER, M. G. and PEARMAN, W. A. **Social work, patient rights and patient representatives.** *Social Casework*, New York, 1978, Feb., vol. 59, no. 2, pp. 89-100.

A part of the present consumers' rights movement is a growing effort to protect the rights of patients in hospitals, nursing homes and psychiatric institutions. There are substantial differences among the statements of rights issued by the American Hospital Association, American Civil Liberties Union, Medical Malpractice Commission, Department of Health, Education and Welfare and the laws of six states, but there are also similarities. Some of the more frequently cited rights in the model drafts and

statutes are given. The development of the new occupation of 'patient representatives' is traced and their role is discussed, with particular reference to their ability to effect change and their position as patients' advocate. The implications for social worker are discussed.

TRANSPORT OF PATIENTS

See Abstract No. 1400

HOSPITAL CARE

See also Abstract Nos. 1302, 1303, 1312, 1324, 1359, 1384, 1395, 1398, 1403, 1412, 1413, 1419

1361. VANDERPOOL, H. Y. **The ethics of terminal care.** *Journal of the American Medical Association*, Chicago, 1978, Feb. 27, vol. 239, no. 9, pp. 850-852.

The phrase 'dying with dignity' has come to symbolize ethical care for terminally ill persons. However, the meaning of this phrase is not at all clear. The ideals invoked by the phrase are examined and their adequacy for the care of the dying is questioned. It is suggested that the essential ethical components of dying should involve the four fundamental features of human worth: respect for the individual; inclusion in a community; concern for the body; and considerations of a broader purpose.

1362. WILLIAMSON, J. W. **Formulating priorities for quality assurance activity: description of a method and its application.** *Journal of the American Medical Association*, Chicago, 1978, Feb. 13, vol. 239, no. 7, pp. 631-637.

The paper suggests a method of selecting areas of health care which should receive priority assurance of quality. The structured procedure recommended consists of five major steps; (i) the selection of a team; (ii) a training session; (iii) an incubation period when particular items and the likely effects of changes are studied; (iv) the priority meeting where topics needing attention are listed; and (v) the final selection of topics by the executive board of the institution concerned. Topic selection procedures in 23 clinics and hospitals are reviewed briefly. Topics produced by a structured procedure seemed to give greater attention to health education and preventive medicine, and a procedure of this kind is especially suited to evaluation studies of the Professional Standards Review Organizations or of the Joint Commission on the Accreditation of Hospitals.

1363. ERTEL, P. Y. and ALDRIDGE, M. G., editors. **Medical peer review: theory and practice.** St. Louis, C.V. Mosby, 1977, xvi, 421pp. $20.00

This is a collection of separate essays by different contributors on the evaluation of health care by peer review systems. The first part deals with the theory of peer review including its evolution, the critical issues involved and the organization of review system. Part two covers the actual practice of peer review describing the basic instruments needed (e.g. the American Medical Association model screening criteria) and samples of functioning systems. A final part discusses the underlying principles of

peer review systems. With the exception of one chapter on the evaluation of primary health care in Britain the book deals solely with American practice. Lists of references are given at the end of each chapter and the book includes a glossary of terms used.

1364. KAUTZKY, R. Menschlichkeit im Krankenhaus. **[Humanity in the hospital.]** *Krankenhaus*, Stuttgart, 1977, Oct., vol. 69, no. 10, pp. 373-378.

It must be remembered that a patient in hospital is not merely a biological machine in need of repair—he is also a psychological problem and a social being. What is required is patient-oriented, rather than disease-oriented, medicine. Both proper contacts between hospital staff and patients and between hospital staff themselves are important if the patient is to be treated humanely. There must also be, what is often lacking, enough contact between relatives and the patient: this is particularly important when the patient is critically ill. More consideration should be given to the patient's interests in discharge procedures—he should not be rushed out prematurely because a bed is needed—and a letter should be sent without delay to his general practitioner so that proper aftercare can start at once.

DISCHARGE OF PATIENTS

1365. THOMS, F. L. and MOTT, R. **A new role for the RN: discharge coordinator.** *Hospital Progress*, St. Louis, 1978, Feb., vol. 59, no. 2, pp. 38, 40.

The traditional approach to discharge planning in which the social worker plays the leading role, is limited because the social worker is not always fully aware of the medical and nursing needs of the patient. In 1974 St. Vincent Charity Hospital, Cleveland, analyzed its discharge planning and received alternative approaches to the problem. It was decided to appoint a registered nurse discharge co-ordinator as a member of the social service department. The social worker continued to act as primary planner and to provide supportive services, while the nurse helped patients and families to make informed choices about facilities. After one year, a follow-up study found that some of the weaknesses in the traditional approach had been eliminated. After two years it is felt that the scheme offers a more comprehensive and professional after-care placement service.

HOME CARE, AFTER-CARE

1366. GAY, P. and PITKEATHLEY, J. **The community care of discharged hospital patients.** *Health and Social Service Journal*, London, 1978, April 7, vol. 88, no. 4585, pp. C9-C16.

The primary object of the Discharged Patients' Survey described was to discover whether there was a role for the volunteer in the care of discharged patients. Interviews were conducted with patients within three weeks of discharge and a 100 per cent response rate was achieved. The findings showed that, although patients were in general well cared for in the area of Oxfordshire and Berkshire under survey, volunteer helpers could be used to back-up family, neighbours and the social service departments. The authors favour the establishment of a volunteer network to help with shopping, transport and visiting. Such schemes should be linked to existing 'good neighbour'

schemes and hospital staff concerned with discharge should be made aware of them. The authors also consider that suitable volunteers could form links with discharged psychiatric patients by first visiting them in hospital.

SPECIAL DEPARTMENTS

ADMISSION UNITS

1367. GRIFFITHS, D. A. T. **Information rooms for operational management in general hospitals—2.** *Hospital and Health Services Review*, London, 1978, May, vol. 74, no. 5, pp. 157-160.

Six information rooms, four in hospitals and two at unit level, are described. The information room at St. George's Hospital, London, handles all except maternity admissions and the current bed state is displayed. A similar system operates at St. Thomas's Hospital. The information room at Whittington Hospital, North London, provides an admissions and doctors' inquiries service (ADIS) which provides up-to-date information to general practitioners and the ambulance service on beds available, arranges patient transport and provides a contact with three community services. A separate ADIS handles maternity admissions for nine hospitals. The information room at Ipswich Hospital keeps detailed waiting lists and charts their movements. At Southampton General Hospital there are three unit information rooms: (i) general surgery; (ii) general medicine; and (iii) traumatic and orthopaedic surgery. A computerized information system for certain surgical beds operating at Walsgrave General Hospital, Coventry, between 1969 and 1971, is also described.

WARDS

See Abstract Nos. 1269, 1284, 1417

OPERATING SUITES

1368. VOGT, V. Den moderna centraloperationsavdelningen—beräknade vinster i fråga om personalutnyttjande och patientgenomströmning. **[The modern central operating theatre unit—estimated savings in the matter of staff exploitation and patient flow.]** *Sjukhuset*, Göteborg, 1978, vol. 55, no. 2, pp. 63-65, 67.

The advantages of central operating units, divided up into some eight to 10 operating theatres serving a maximum of four specialties, are: (i) that the theatre nurses are highly qualified; (ii) operations can be planned utilizing related specialties; (iii) first class anaesthesia is available; (iv) they economize on staff; (v) waiting times for patients are reduced; (vi) rotas are more easily arranged; (vii) a high percentage utilization of accommodation is achieved; and (viii) highly qualified staff are on hand for acute cases. The disadvantages of large departments are: (i) poor contact and control from above down; (ii) staff can never learn all the specialties on offer; (iii) economies in equipment and staff can be lost in reduced efficiency; (iv) large numbers of staff

increase the risk of cross-infection, whilst shortage of staff causes the system to break down; and (v) staff change round so often that they never get into a routine. The Swedish Hospital Rationalization Unit is investigating the best ways and means of utilizing operating units. Architects designing operating theatres should put flexibility at the top of their list of priorities.

PHARMACY

1369. DUGAS, J. E. and BROWN, S. **Community mental health centers; a milieu for expansion of pharmacist services.** *Hospital Pharmacy*, Philadelphia, 1978, Feb., vol. 13, no. 2, pp. 78, 81-82, 84, 86-87.

The Capitol Region Mental Health Center, Hartford, Conn., opened in July 1974 to provide high-quality community-based mental health services, including diagnosis, treatment, after-care and rehabilitation for in-patients, day patients and out-patients. This paper describes the comprehensive pharmaceutical services provided by the centre, focusing on the development and nature of the programmes and attempting to indicate the kinds of benefits from such a programme. The centre has only one pharmacist who is on duty 46 hours a week during normal clinic hours from Monday to Friday. The services he provides include: medication distribution; primary clinical care; drug information and education; and quality assurance. The programmes were developed individually and sequentially to meet specific needs of the centre's staff and patients and were designed to be in keeping with the centre's overall mission of providing care.

1370. RUGER, J. R. and MICHELSON, P. A. **A survey of concepts and practices of drug information services.** *Hospital Pharmacy*, Philadelphia, 1978, Feb., vol. 13, no. 2, pp. 90-92, 96, 98, 100.

A 28-question survey (reproduced as an appendix) was mailed to 61 drug information centres across the United States; there were 42 replies (68.1 per cent). The scope of the services provided by the centres is as diverse as the regions of the country in which they exist. Some centres provide a continuous, high output of information while other centres are not subject to such pressure. There is no standard format to the services provided. The implementation of standards may be an asset to some centres and a hindrance to others in which funds and manpower are scarce. Replies to the questions relating to library and information science indicate the need for specialized education in this area.

1371. SCHNEIDER, P. and CABLE, G. **Compliance clinic: an opportunity for an expanded practice role for pharmacists.** *American Journal of Hospital Pharmacy*, Washington, 1978, March, vol. 35, no. 3, pp. 288-295.

A pharmacy-based compliance clinic, operating at the Ohio State University Hospital since 1976, helps patients who fail to follow their prescribed drug routine. Physicians refer patients to the pharmacist who attempts to discover the personal and social reasons for non-compliance and suggests ways of overcoming the patient's problems. If the patient displays a negative attitude the pharmacist must convince him of the importance of drug therapy in the management of his disease. Several aids are

used to simplify complex drug regimes, such as calendars and 'unit-of-use' packaging. There have been 13 referrals to the clinic, eight of whom are still attending. Although not yet formally evaluated, the scheme has obviously contributed to a comprehensive pharmacy service.

LABORATORIES

See also Abstract Nos. 1320, 1344

1372. LOCHOUARN, M. and MARON, C. L'organisation d'un service central de triage: l'exemple de l'hôpital Lariboisière. **[The organization of a central triage department: the example of Lariboisière Hospital.]** *Hôpital à Paris*, Paris, 1978, Jan./Feb., no. 43, pp. 17-23.

At the Lariboisière Hospital a centralized service with a staff of eight is now responsible for the 1,800 samples per day which have to be collected from the wards and clinics and delivered to the seven laboratories. Collections are made at 0900, 1100 and 1300 hours; the samples are sorted at a central point and delivered to the appropriate laboratory. On average, 75 per cent of samples arrive at the correct laboratory before 1000 hours. Most results are delivered to the wards and clinics by 1700 hours. The staff use trolleys loaded with 20 containers each of which holds 103 test-tubes. They supply fresh test-tubes, containers and labels to each ward or clinic once a week. Centralization has proved to be efficient and labour-saving.

1373. ALLER, R. D. and others. **Computer-assisted Pathology Encoding and Reporting System [CAPER].** *American Journal of Clinical Pathology*, Philadelphia, 1977, Dec., vol. 68, no. 6, pp. 715-720.

The programs for this system were written in MUMPS (MGH Utility Multi-Programming System) for a Digital Equipment Corporation PDP-15 computer with three moveable-head disk drives and 48K words of memory. Four INFOTON CRT display scopes serve as terminals, with an average response time of less than one second. The system performs clerical functions, including the accessioning of specimens, monitoring their state of completion, production of log books, billing, statistics and transfer of diagnosis to other hospital departments. It also permits instantaneous display of all diagnoses rendered within two years, printout within 24 hours of all older diagnoses for any patient, and retrieval of all specimens with any given diagnoses, further defined by any data item (e.g. age), stored in the computer file.

1374. PRICE, L. W. **Setting up a biochemistry laboratory.** *Middle East Health*, Sutton, 1978, April, vol. 2, no. 4, pp. 41-42.

While serving primarily as a clinical laboratory, the biochemistry laboratory will also have sections for research into particular aspects of biochemistry. This fact, together with the availability of technicians and specialist expertise, should be considered when planning the layout of a laboratory and ordering equipment. A laboratory for each particular discipline is preferable to a standardized system. Some equipment requires careful positioning, for example, fume cupboards and atomic absorption spectrophotometers. Special supplies and equipment needed include: (i) compressed air and de-ionized water; (ii) special electrical supplies; (iii) refrigerators and incubators;

(iv) various types of temperature control systems; (v) laboratory pH meters; (vi) different types of spectrophotometers; and (vii) a fraction collector. The decision whether to acquire diagnostic kits and automatic analytical systems should be based on a consideration of running and service costs as well as on the purchase price.

BLOOD TRANSFUSION DEPARTMENT

1375. SCHWARTZ, L. M. and MILES, W., editors. **Blood bank technology. 2nd edition.** Baltimore, Md., Williams & Wilkins, 1977, xviii, 312pp. $16.00

The science of blood banking has become increasingly interrelated with all other fields of medicine, particularly in the diagnosis and treatment of disease. This volume is divided into four sections. Section one covers areas in which knowledge is generally limited or controversial, or views have changed with progress; section two includes some theoretical aspects of blood banking; section three includes abstracts from the literature which reveal individual aspects related to immunohaematology; and section four is composed of exercises in blood bank technology for self-instruction.

1376. ARBAT SELLABONA, J. Organizacion de un banco de sangre. **[Organization of a blood bank.]** *Policlinica*, Barcelona, 1978, Feb./March, no. 44, pp. 30-32, 34-36, 39-40, 42, 45.

A summary is presented of the most important norms to be observed with regard to the operation of a blood bank, with short notes on: examining the donor, taking the donor's blood, plasmapheresis, blood grouping, Rh classification, other blood factors, antiglobulin, cross matching, transfusions of total blood, sterility checks, serological tests, plasma transfusions, delivery to the patient, delivery of blood of a different group, rules for the interchange of blood between banks, and the complications which may follow a transfusion. The need to keep accurate day-to-day records is emphasized, since their absence may cast doubts on the competence of the blood bank. These records should include the donor's name, the results of all tests, a note on any incidents which occurred during donation, the name of the person who took the blood, the equipment used, results of tests, a register of all requests for transfusions and the results of cross matching, a record of all transfusions, the composition of any plasma mixtures with the donors' names and the numbers of the flasks used, and a record of any reactions which occurred.

1377. LAZZARA, A. Il servizio immuno-trasfusionale collegato con l'ospedale di giorno come centro di prevenzione e trattamento delle emopatie. **[The immune-transfusion service in association with the day hospital as a centre for the prevention and treatment of haemopathy.]** *Ospedale*, Torino, 1978, Jan./Feb., vol. 31, nos. 1-2, pp. 3-6.

On the basis of experience obtained since 1973 in the Villa Sofia Hospital in Palermo, the author recommends that cases of haemophilia, thalassaemia, and other diseases of the blood be treated in day hospitals, which have appropriate laboratory facilities. These centres should also be involved in the early detection of cases of thalassaemia (particularly widespread in Mediterranean countries) and make free blood tests available to all pregnant women. The advantages of the day hospital structure are

mainly economic; however, many of the haemophilic and thalassaemic patients are infants and young children and this type of arrangement avoids the painful separation of mother and child.

RADIOISOTOPE DEPARTMENT

See Abstract No. 1355

REHABILITATION

See Abstract No. 1418

DEPARTMENTS FOR SPECIAL THERAPY

See also Abstract No. 1408

1378. TOSHNEY, J. **An alcoholism and detoxification centre.** *Nursing Times*, London, 1978, April 6, vol. 74, no. 14, pp. 573-576.

The alcoholism treatment unit at Withington Hospital, Manchester, has provision for 20 in-patients and is equipped with group treatment and seminar rooms. Referrals are accepted from a wide range of sources and the operational policy is based on ease of access and speedy assessment. Great attention is paid to staff needs as nurses are usually very inexperienced in dealing with alcoholics. Assessment is made at out-patient clinics and admission is avoided where possible. Nurses and treatment teams are responsible for implementing the treatment programme, which takes the form of group meetings and discussions. Patients are brought to the detoxification centre by the police and their long-term needs are assessed over a period of 10 days. Nurses are concerned with the reception of patients and the 'drying-out' process, and a high degree of adaptability is required.

INTENSIVE CARE UNITS

See also Abstract Nos. 1279, 1338

1379. ERIKSSON, K., WIDÉN-HUGGARE, B. and DAHLIN, S. Sju sjuksköterskor i Qatar: jobbigt, lärorikt, roligt att bygga upp landets intensivvård. **[Seven Swedish nurses establish intensive care unit in Qatar.]** *Vårdfacket*, Stockholm, 1978, April 27, no. 8, pp. 5-11.

The population of Qatar is divided between 150,000 in the capital, Doha, and the remaining 30,000 in small villages or in the desert; 70 per cent are immigrants. Rumillah General Hospital in Doha has 420 beds; there is also a 180-bed women's hospital and a 120-patient psychiatric home, with a tuberculosis clinic. A new 600-bed hospital should open in the 1980s. The seven Swedish nurses established a five-bed intensive care unit in February 1977, assisted by a Qatari doctor, 12 Philippino nurses and five 'boys'. On arrival, the nurses found a new ward containing five beds, respirators and monitoring equipment. The chief nursing officer attempted to apply English hospital discipline from the first day, something quite foreign to the nurses, who had come to set up and run the ward on Swedish lines. The pharmacy had to be reorganized, and

all equipment ordered from Sweden or England, or built by the nurses themselves. Their most difficult job was composing work routine instructions in English for the Philippino nurses, who were trained to take orders and not work as members of a team. There was little knowledge of intensive care procedures and doctors were not inclined to accept the advice of women. To begin with, only terminal cases were sent to intensive care, the majority of patients being severe traffic casualties or burns. At the end of 10 months the nurses left the ward functioning reasonably independently under its doctor and one Indian anaesthetist, but they failed to persuade the doctors to take part in discussions on treatment. The article is illustrated with five photographs.

1380. SPOONER, R. B., editor. **Hospital instrumentation care and servicing for critical care units.** Pittsburgh, Penn., Instrument Society of America, 1977, iii, 188pp. £6.20

This book provides a basic text and reference for training biomedical equipment technicians so that they can contribute fully to the successful operation of intensive care units, since it is the responsibility of the biomedical equipment technicians to keep the instrumentation working properly. The 15 chapters of the text cover some of the more important and widely used types of hospital instrumentation. Each chapter has been written by an expert in that field of instrumentation and covers the aim of the instrument, a description of it, how it operates, techniques for achieving best results, preventive maintenance, circuitry and possible problems. The types of instrumentation discussed include: EKG amplifiers; arrythmia monitors; blood pressure instruments; electronic thermometers; respiratory monitors; oxygen monitors; blood-gas analyzers; cardiac-output analyzers; medical CRT displays; recorders; cardiac pacemakers; defibrillators; and test instruments.

1381. MCLEOD, A. A. and JEWITT, D. E. **Role of 24-hour ambulatory electrocardiographic monitoring in a general hospital.** *British Medical Journal*, London, 1978, May 6, vol. i, pp. 1197-1199.

During 1976, 24-hour ambulatory electrocardiographic (ECG) monitoring was available to all physicians at King's College Hospital, and 281 patients were investigated by 322 recordings. Cardiac arrhythmias requiring treatment were detected in 100 patients. Some had symptoms such as faintness and palpitations, but serious arrhythmias were also found in patients free of symptoms. A demand pacemaker was implanted in 30 patients and 70 required drug treatment. A younger age group with sinoatrial disorders was revealed and a precise diagnosis was obtained for most of the patients studied, demonstrating the need for 24-hour ECG monitoring in a large general hospital.

SPECIAL HOSPITALS AND UNITS

OUT-PATIENT

See also Abstract Nos. 1392, 1418

1382. LOUDON, I. S. L. **Historical importance of outpatients.** *British Medical Journal*, London, 1978, April 15, vol. i, pp. 974-977.

This paper describes the sudden rise in out-patient attendances at voluntary hospitals

between about 1830, and 1910, and its effect on the development of clinical medicine in Britain. The author quotes numbers of out-patients during these years at several hospitals in London and elsewhere. Analysis of the out-patients shows that the largest rise was among casualties, in the sense of 'casual attenders' without recommendations. Out-patient departments became a major source of conflict between general practitioners and hospitals and various committees wrote detailed, if ineffectual, reports about the overcrowding and poor quality of care. The need for reform led eventually to the introduction of referral. If the eighteenth century dispensary system had survived, health centres run by general practitioners, rather than by hospital out-patient departments, might have become the main focus of out-patient care.

1383. REISMAN, A., MELLO DA SILVA, J. and MANTELL, J. B. **Systems and procedures of patients and information flow.** *Hospital & Health Services Administration*, Chicago, 1978, vol. 23, no. 1, pp. 42-71.

The object of this study was to investigate various systems and procedures for out-patient flow and recommend improvements. The authors describe the appointment-making practices in use at a particular clinic and their associated problems, including: (i) long waiting times for initial visits, often resulting in cancellations; (ii) the non-availability of examination rooms; and (iii) lack of job training and job classification for staff. Several proposals for producing a smooth-running system are given. The recommendations related to staffing include: (i) a patient-flow procedures manual; (ii) systematic staff training; and (iii) a re-classification of jobs. Those relating to patient scheduling include: (i) provision of 'stand-by' time; (ii) pre-scheduling of laboratory tests and X-rays; and (iii) a patient flow information data bank, allowing for up-dating of appointments both departmentally and centrally. Advice is given on how to implement the approved system.

1384. COLEMAN, J. R. and KAMINSKY, F. C. **Ambulatory care systems. Volume IV. Designing medical services for health maintenance organization.** Lexington, Mass., Lexington Books, 1977, xxxiv, 445pp. £16.50

The aim of this book is to make available to health planners and Health Maintenance Organization (HMO) planners new technology and data bases which can be used during the feasibility and planning stages of a new HMO. Aspects covered include: (i) the evolution and characteristics of HMOs; (ii) creating the HMO; (iii) defining and sizing the service population; and (iv) planning medical care, hospital care, mental health care, dental care, vision care and prescription drug systems. A glossary of terms and an appendix listing the prepaid medical care plans used throughout the book are included.

1385. KOLTUV, M., AHMED, M. B. and MEYER, M. **A study of out-patient satisfaction with mental health center services.** *Hospital and Community Psychiatry*, Washington, 1978, March, vol. 29, no. 3, pp. 179-181.

In 1972 the authors conducted a study to determine the effect of encouraging patients to express disatisfaction with services received at a community mental health centre in New York City. A total of 270 out-patients, who had visited the centre over a period of six months, were sent letters asking for suggestions and complaints and listing staff members to whom these could be directed. Follow-up telephone interviews were

conducted with 52 patients who had received the letter and 53 who had not. The former group expressed a more general satisfaction with the service and had fewer complaints than the non-recipients. However, where complaints did exist, patients did not use the channels open to them. This shows that a mechanism inviting complaint will put very limited pressure upon the services given.

CASUALTY AND ACCIDENT

1386. WILLEMAIN, T. R. and LARSON, R. C., editors. **Emergency medical systems analysis: papers on the planning and evaluation of services.** (Urban Public Safety Systems Volume IV) Lexington, Mass., Lexington Books, 1977, xxix, 177pp. £12.50

The aim of the research presented here was to attempt to provide a bridge between a growing body of analytical techniques for urban services analysis and the field of emergency medical services (EMS) planning in the United States. The eight chapters form a map of the EMS system and trace the problem of EMS planning through the formulation of system goals and performance criteria; the development of systemic relationships among components; the public's forward role as first medical decision-makers; the initial response of the EMS system to a request for service; the provision of emergency transportation; the provision of care in a hospital setting; and the connection between the system and clinical results.

1387. L'aide médicale urgente. **[Medical emergency services.]** *Hospitalia*, Bruxelles, 1977, vol. 21, no. 4, pp. 164-207.

A collection of eight articles on emergency services in Belgium. They deal with: (i) the levels of provisions in recognized hospitals; (ii) the emergency treatment of emotional crises; (iii) the need for an emergency department in every regional hospital; (iv) how to employ emergency department staff in small hospitals during slack periods; (v) emergencies in general practice; (vi) the University of Louvain Clinic emergency service; (vii) the assessment of the numbers of cases of acute mental illness (potential suicides) requiring immediate treatment, in Brussels; and (viii) the establishment of a medical team available round the clock to go out to emergency cases.

1388. BREAN, L. and others. L'organizzazione e la strutturazione del dipartimento di emergenza traumatologica. **[The organization and structure of an emergency department of traumatology.]** *Revista degli Ospedali*, Roma, 1977, Oct., vol. 9, no. 10, pp. 409-415.

The author summarizes Italian legislation relating to emergency departments and briefly reviews current thinking on the subject. He then describes the plan to create a specialized traumatology unit at the C.T.O. (Centro Traumatologico ed Ortopedico) Hospital at Turin, which will treat all the serious accident cases in the area. Because of the high incidence of head injuries, the staff will include a neurotraumatologist as well as orthopaedic and general surgeons. The emergency unit will be managed in rotation by the orthopaedic and traumatology departments so as to ensure continuity of care and 24-hour availability of a multidisciplinary team able to deal with any type of injury. Finally, the author touches briefly on the social, didactic, and scientific functions of the unit.

1389. SILER, K. F. **Level-load retrieval time: a new criterion for EMS facility sites.** *Health Services Research*, Chicago, 1977, vol. 12, no. 4, pp. 416-426.

A new criterion for locating emergency medical services, known as level-load retrieval time, was incorporated into a model and applied to Los Angeles County. Level-load retrieval time combines retrieval times from points served by each emergency centre with patient load on each centre. Although the retrieval times from various centres increased by five to 10 per cent, the patient load became much more uniform. The new criterion, when used to complement other planning factors, may help to reduce excessive demand on overload emergency service facilities.

1390. HOWELL, R. G. **Accident and emergency services: how does your department compare?** *Hospital and Health Services Review*, London, 1978, April, vol. 74, no. 4, pp. 116-118.

In an operational study of a large accident and emergency department it was decided to concentrate on: (i) the time patients had to wait for treatment; and (ii) how long they spent in the department before being discharged. The 'average' and 'range' of times patients spent in the department were calculated. A computer-based simulation model was used to test the likely effects of possible changes. By increasing the number of casualty doctors from two to three, the model predicted that the waiting time of 50 per cent of patients would be reduced from the existing 32 minutes to 24 minutes and of 90 per cent from 76 to 54 minutes. The model was also used to predict the effect on the service of an increase in the number of new patients. A simulation model of this type is simple and inexpensive to run.

1391. LANE, D. S. and EVANS, D. **Study measures impact of emergency department ombudsman.** *Hospitals*, Chicago, 1978, Feb. 1, vol. 52, no. 3, pp. 99, 100, 102, 104.

A study of the emergency department at Brookhaven Memorial Hospital, Patchogue, N.Y., suggested that the immediate solution to patients' complains was not simply to increase the size of the clinical staff, but rather to add the services of a patient ombudsman. The ombudsman appointed as a result serves as a liaison between the hospital and the patient. His function includes interpreting emergency department policy and procedures, making patients and their families comfortable, providing information on the process and progress of care, reinforcing instructions, facilitating follow-up and referral, resolving grievances and suggesting improvements in patient flow and service. The ombudsman is independent of staff supervision within the department. A study of a sample of 112 patients indicated that an ombudsman can alleviate some of the complaints that plague emergency departments. Although length of visit was not significantly reduced, patients and their companions were less concerned about waiting time and were better able to understand and accept delays.

1392. PLANT, J. and AMES, S. **Emergency/outpatient satellites serve as rural outposts.** *Hospitals*, Chicago, 1978, March 1, vol. 52, no. 5, pp. 87-88, 90-92.

When physician recruitment problems and sudden population growth placed a severe strain on several New Hampshire communities, civic and hospital leaders pooled resources to develop emergency/out-patient centres as satellites of St. Joseph Hospital, Nashua, N.H. Each satellite (at Milford and Merrimack) is fully equipped to perform

most procedures normally done in a hospital-based emergency department, with the exception of procedures that require a general anaesthetic. Physical, respiratory and speech therapy departments offer the full range of services available at the hospital. Basic diagnostic laboratory, radiology and cardiology services are also provided. The satellites are staffed seven days a week from 0700 to 2300, though some services are only available from 0800 to 1630. Medical and paramedical staffing is provided on a contract basis. There is a full-time and part-time nursing schedule and a full-time receptionist for each of the two shifts. The work done by the satellites, their financing and their impact are discussed.

DAY HOSPITALS

See also Abstract No. 1377

1393. WOOLLACOTT, S., GRAHAM, P. and STEVENSON, J. **A controlled evaluation of the therapeutic effectiveness of a psychiatric day centre for pre-school children.** *British Journal of Psychiatry*, London, 1978, April, vol. 132, pp. 349-355.

The progress over one year of 25 children, aged over two years but under four, and attending the psychiatric day centre at the Hospital for Sick Children, London, was compared with that of 25 similarly disturbed children from a total population of a London borough. The two groups were similar in behaviour, nature of family background and in the attitude of the mothers to their child's behaviour problems. The control group had no psychiatric help during the year under study, but both groups had attended pre-school facilities. Both groups displayed improved behaviour over the year, thereby showing that the gains in the treated group were very modest in proportion to the resources invested. The therapeutic work of the day centre is therefore being reconsidered, but the importance of its supportive function must not be undervalued.

INFECTIOUS DISEASES AND ISOLATION

See Abstract No. 1342

CHILDREN

See also Abstract No. 1393

1394. **The child and the unexpected.** *Journal of the Institute of Health Education*, Sheffield, 1977, vol. 15, no. 2, whole issue, pp. 5-39.

This feature presents the papers given at an Institute of Health Education conference to mark the centenary of the Sheffield Children's Hospital. The papers are on: the pattern of child death today and its relation to the community; the use of child care services related to unexpected death in infancy; learning to deal with personal crises; congenital deformities; fatal disease in childhood; the adopted child; and the co-ordination of care.

1395. HALL, D. J. **Bedside blues: the impact of social research on the hospital treatment of sick children.** *Journal of Advanced Nursing*, Oxford, 1978, Jan., vol. 3, no. 1, pp. 25-37.

Ways of improving the hospital environment for children, suggested by research

over the past 30 years, have often been reluctantly introduced. Policies of unrestricted mother-child visiting are now generally accepted but problems are caused by strict adherance to 'rule of thumb' judgements rather than consideration of individual children's needs and family relationships, and by lack of attention given to the role of mothers in the wards and their relationship with the nurses. Similar tension is now being caused by the fulfilment of children's recently accepted need for play. Although committed and enthusiastic ward staff have successfully encouraged play schemes, resistance to change is more often marked, and the timidity of official bodies tends to support the status quo. There is clearly a need for research and practice to co-operate more closely.

1396. PERRIN, E. C. and GOODMAN, H. C. **Telephone management of acute pediatric illnesses.** *New England Journal of Medicine*, Boston, 1978, Jan. 19, vol. 298, no. 3, pp. 130-135.

In order to evaluate the telephone management of five common acute paediatric problems, a 'programmed mother' made unidentified calls to five paediatric nurse practitioners, 28 paediatric house officers and 23 paediatricians in practice. Calls were tape recorded for history taking, disposition and interviewing skill. Nurse practitioners averaged 79.6 per cent of the total possible theoretical score for history taking, house officers 69.1 per cent and practising paediatricians 52.6 per cent. For disposition nurse practitioners averaged 71.1 per cent of the maximum score in contrast to 60.1 per cent for house officers and 58.9 per cent for practising paediatricians. Paediatric nurse practitioners appear to manage common paediatric problems by telephone better than house officers or practising paediatricians, and improved training for this aspect of practice is recommended.

1397. LÖFQVIST, J. Barn- och ungdomspsykiatrisk klinik jämte habiliteringsenhet för rörelsehindrade barn och ungdomar i Malmö. **[A psychiatric unit for children and young people and a therapy unit for disabled children and young people in Malmö.]** *Sjukhuset*, Göteborg, 1978, vol. 55, no. 3, pp. 173, 175, 176, 179.

A new psychiatric unit (architects: Kelfve-Thornberg Arkitektkontor AB) was established in the grounds of Malmö General Hospital in 1976. It consists of two broad, single-storey pavilions connected by a long, three-storey block. The buildings are sited in a therapeutically landscaped play-park protected from noise and traffic by a four to five metre high wall. The southern pavilion houses the closed unit of 37 beds in four, eight-bed wards and a five-bed acute ward. The three-storey block contains the open-care wards, play-room, psychologist's office, therapeutic team rooms, and offices. The ground floor houses therapy departments and a school, the rehabilitation treatment centre (physiotherapy and occupational therapy departments), baths, gymnasium, exercise rooms and changing rooms. The northern pavilion contains the therapy and play unit for 65 physically disabled and healthy children, plus a small infants' unit. The entire environment contributes to the therapeutic situation. The article is illustrated with one exterior and one interior photograph and a ground plan of the entire unit.

1398. GYULAY, J.-E. **The dying child.** New York & London, McGraw-Hill, 1978, xiii, 192pp. £6.25

The aim of this book is to consider children who are dying, whose lives have been shortened by incurable illness, congenital anomalies, sudden, unexpected death or

irreversible injuries. Death is examined as another facet of the *life* experience. The book is in four sections: (i) the child—including children, older children, special children; (ii) the grievers—including parents, siblings and significant others; (iii) illness and death in which the six stages of death: the beginning, the reprieve; the ultimate reality; the terminal state; sudden loss; and the post death period; are considered; and (iv) the nursing process involving the care of the dying child. Detailed bibliographies referring to each of the sections are included.

1399. RAGGI, G. C. and BILIO, M. A. Di. Influenza della presenza materna sul comportamento del lattante ospedalizzato. **[The influence of the presence of mothers on the well being of hospitalized babies; consideration of 200 cases.]** *Revista degli Ospedali*, Roma, 1977, Oct., vol. 9, no. 10, pp. 416-425.

The authors compared the behaviour of 100 children aged from four to 14 months whose mothers stayed with them in hospital with that of another 100 of the same ages whose mothers could not be with them. They observed the children's feeding, crying, play and sleep patterns, and their reactions to their environment and to treatment. They also visited some of the children in each group after their return home. The children in the first group were difficult, aggressive, and slept badly in hospital, while those in the second group suppressed their anguish, ignored their family at visiting times, and slept better. However, when they returned home, these children clung to their mothers much more than those in the first group; they slept badly, treated all strangers with suspicion, and were obviously frightened that their mothers would abandon them again. The study confirmed that view that mothers should accompany their small children for the duration of their stay in hospital.

1400. GUNN, T. and OUTERBRIDGE, E. W. **Effectiveness of neonatal transport.** *Canadian Medical Association Journal*, Ottawa, 1978, March 18, vol. 118, no. 6, pp. 646-649.

Since 1964 Montreal Children's Hospital has run a transport service in which it has sent out its own staff and equipment to transport referred newborn infants. The condition of 259 infants transferred to the neonatal intensive care unit (NICU) from 1 October 1974 to 31 March 1975 was evaluated. When the transport team arrived at the referring hospital, hypothermia (temperature of less than 36°C) was present in 25.2 per cent of the 163 infants for whom complete temperature measurements were available. Most (77.3 per cent) of the infants were warmed during transport and only 3.1 per cent arrived at the NICU with a temperature of less than 35°C. Mortality was significantly higher in babies of all birth weight groups whose care temperature had been below the optimal temperature for survival (36 to 37°C). It appears that the use of appropriate equipment and trained staff can reduce the incidence of hypothermia and therefore the mortality in infants requiring transfer.

GERIATRICS AND LONG-STAY

See Abstract Nos. 1317, 1397

1401. DRESSLER, D. M., ACCETTULLO, D. and CORVI, B. **Hospital, nursing homes become partners in psychiatric care.** *Hospitals*, Chicago, 1978, March 1, vol. 52, no. 5, pp. 93-94, 96.

New Britain (Conn.) General Hospital has been offering a special psychiatric

programme to nearby convalescent and nursing homes. During the first two years of the programme, about 20 patients were taken from one nursing home to the hospital on a weekly basis to attend a treatment group. Due to dissatisfaction with this arrangement a psychiatric programme was established within the nursing home itself. Following screening of patients in the home, three types of therapy groups were instituted: (i) socialization of patients who show limited potential for change; (ii) socialization of patients who have a higher potential for change, including rehabilitation; and (iii) for patients who have the potential to leave the facility. In recent years the programme has been further developed to include five additional nursing homes. At present, about 175 patients are seen on a weekly basis, mostly in therapeutic groups. Overall, the programme has been extremely successful in meeting its objectives.

1402. SCHUMAN, J. E. and others. **The impact of a new geriatric program in a hospital for the chronically ill.** *Canadian Medical Association Journal*, Ottawa, 1978, March 18, vol. 118, no. 6, pp. 639-642, 645.

On 1 April 1975 St. Mary's of the Lake Hospital, Kingston, Ont., a 210-bed chronic care hospital, introduced a new programme which aimed to provide better patient care, and education in geriatrics and chronic care for medical house staff. The philosophy of rehabilitation permeates the programme. Its major components are: full-time medical and house staff; a formal section for physical medicine; a team approach with team audit; problem-oriented medical records; intensive in-service teaching; a geriatric out-patient department; and a day hospital. After the first year of the programme, patient outcome had improved and more efficient use was being made of continuing care beds because of larger numbers of patients being discharged home after shorter stays. This may be one way of decelerating Canada's dismal rate of institutionalization.

1403. EPSTEIN, G. **Learning to care for the aged.** Reston, Va., Reston Publishing Co., 1977, xiii, 219pp. £5.25

This book mixes formal and informal data on the care of the elderly and in so doing attempts to point out the intellectual and practical gaps in our approach to ageing. Aspects considered are: (i) attitudes and behaviour towards ageing and the aged; and (ii) exercises in awareness and skill development which include ambivalence; stereotyping; behaviour of professionals; identifying job factors; identity and dignity; and learning to grow old.

1404. MACKEPRANG, B. and BENTZON, M. W. **Minimum need for care in geriatric institutions.** *Scandinavian Journal of Social Medicine*, Stockholm, 1978, vol. 6, no. 1, pp. 25-29.

On the basis of a study concerning mortality and changes in patients' needs for nursing care over a two-year period, a calculation was made of the type of care needed at certain times. A statistical model was applied to the example of a geriatric institution accepting only independent patients who remained there until they died. It was found that the need for care became stabilized after a period of five to six years and remained at a level of 45 per cent independent, 38 per cent slightly dependent, and 17 per cent heavily dependent patients. When planning homes for the independent elderly, these findings could be helpful in deciding whether to: (i) admit patients whose need for care may increase; (ii) enlarge the quota of staff to meet these needs; or (iii) provide for the transfer of patients whose need for care changes.

1405. LEVEY, S. and LOOMBA, N. P. **Long-term care administration: a managerial perspective.** Volume 1. New York, Spectrum Publications, 1977, [xii], 308pp. £12.65

The first volume of this book is devoted to the discussion of various aspects of long-stay care administration in the United States. It consists of five chapters: (i) long-stay care; (ii) management; (iii) value systems and long-stay care; (iv) systems; and (v) decision-making. It attempts to relate the various management tools which can be used to develop the best long-stay services. The book has been published in two separate but sequential parts, and each volume has been structured into a complete unit with its own plan of organization, author index and subject index.

CANCER

1406. PRIEST, S. L., CLIVE, R. E. and NEITLICH, H. W. **Various experts work to shape computerized tumor registry.** *Hospitals*, Chicago, 1978, Jan. 16, vol. 52, no. 2, pp. 69-70, 72.

In 1970 the 322-bed Brockton (Mass.) Hospital established a computerized tumour registry to provide high quality and standardized data for analysis of cancer treatment and diagnosis, to ensure that cancer patients receive annual physical examinations, and to provide follow-up data. When it became inadequate three other hospitals joined with Brockton Hospital to initiate a combined registry. This paper describes the two-year development of the project which was accomplished in four major steps: (i) definition of input and output requirements; (ii) design and testing of a data collection form for transcribing data from medical records to the computerized registry; (iii) programming and acceptance of the computerized output; and (iv) using the computerized registry to present relative and observed survival statistics.

EAR, NOSE AND THROAT

1407. GERSTMAN, H. L. **Speech and hearing services in hospitals.** *Hospital Progress*, St. Louis, 1978, Feb., vol. 59, no. 2, pp. 64-67, 75.

The need for speech and hearing services is demonstrated and the case made for placing them in hospitals. Establishing a communication disorders unit in a hospital requires identifying needs, setting objectives and developing a programme that has appropriate capital support. The aspects discussed in this paper include staff size, accommodation and finance. A typical expense budget is given, together with a method for determining fees and a typical fee schedule.

CARDIOLOGY

See Abstract No. 1381

UROLOGY

1408. GIORCELLI, M. and others. Valutazione della situazione epidemiologica in un centro dialisi durante 4 anni di attivita. **[Evaluation of the epidemiological situation in a central dialysis unit during four years of activity.]** *Ospedale*, Torino, 1978, March, vol. 31, no. 3, pp. 65-67.

A total of 128 patients was treated in 19,520 sessions at the dialysis centre in the Mauriziano Umberto I Hospital in Turin during the period September 1973 to September 1977. This centre has eight machines for chronic cases and two for acute cases. The staff consists of four doctors, six nurses, and five auxiliaries. The measures taken to prevent infection include sterilization of all equipment with formalin and hypochlorite, isolation of critical points in the extracorporeal circuit with disposable materials, the cleaning of all surfaces with disinfecting solutions after use, sterilization of all instruments, and the extensive use of disposables. Over the four-year period no cases of Hb Ag +0 Hb Ag hepatitis have occurred among patients; there has been one case of Hb Ag hepatitis in a nurse; no cases of cross-infection have occurred and there have been 10 cases of a hyperpyretic reaction with negative blood cultures. The lack of cross-infection is attributed to the high standards of hygiene observed and to the use of highly trained staff.

MATERNITY

1409. HARDY, C. T. and EKBLADH, L. **Hospital meets patient demand for 'home-style' childbirth.** *Hospitals*, Chicago, 1978, March 1, vol. 52, no. 5, pp. 73-74, 79-80.

Despite its flexible and liberal policies in maternity care, North Carolina Memorial Hospital, Chapel Hill, received a significant number of patient requests that would minimize the institutional and medical aspects of their care. The hospital established a committee which included professional practitioners and consumers to develop appropriate responses. Through a series of compromises, the committee was able to meet patient demands while maintaining the benefits of medical and institutional care. The steps taken include: (i) development of a delivery room which is more like a bedroom at home but retains the benefits of hospital care; (ii) more liberal visiting policy; and (iii) revised medical procedures. Details are given of the way in which the environment of the home-style delivery room was changed. The room has only been in use for a short time, but although 10 to 15 per cent of patients who have begun labour and delivery in it have had to be moved to a regular room, 60 home-style deliveries have been accomplished without major complications. Some initial problems have been overcome.

1410. HOWIE, P. **Induction of labour—does it save babies?** *Nursing Mirror*, Sutton, 1978, March 30, vol. 146, no. 13, pp. 21-24.

Induction of labour at Glasgow Royal Maternity Hospital rose from a rate of 15 per cent of deliveries between 1966 and 1970 to 33 per cent between 1971 and 1975. During this time, the perinatal mortality rates from unknown causes and from birth trauma fell significantly, owing to the prevention of post-maturity and its complications. However, except in certain defined cases, the decision to induce is not easy to

make, and studies and controlled trials carried out so far have led to no definite conclusions. Large scale prospective studies need to be undertaken, so that current skills in the control of labour may be used to the best advantage.

PSYCHIATRY

See also Abstract Nos. 1303, 1304, 1358, 1369, 1378, 1385, 1393, 1396, 1397, 1401

1411. STEIN, L. I. and TEST, M. A. **Alternatives to mental hospital treatment.** New York & London, Plenum Press, 1978, viii, 327pp. £17.33

This book considers the treatment of the patients with chronically disabling psychiatric illness, a condition that, until recently, has been 'treated' by hospitalization lasting many years. The papers presented are derived from the proceedings of a conference held on 'Alternatives to Mental Hospital Treatment' held in Madison, Wisconsin, October 1975. Aspects considered include: (i) the rationale for creating alternatives to mental hospital treatment; (ii) controlled experiments of alternatives to mental hospital treatment programmes; (iii) examples of systems of alternatives to mental hospital treatment; (iv) the British experience; and (v) planning and implementing models for change. References are given at the end of each chapter.

1412. PEPLAU, H. **Psychiatric nursing: role of nurses and psychiatric nurses.** *International Nursing Review*, Geneva, 1978, March/April, vol. 25, no. 2, pp. 41-47.

This paper distinguishes between nurses who practise in psychiatric settings (i.e. nurses with only a basic nursing education, of which a part includes knowledge and supervised practice related to psychiatric work) and psychiatric nurses (i.e. those with specialized post-basic nursing education and therefore have more knowledge and competence for their work). Some characteristics of patients living in hospital are reviewed and activities for the two groups of nurses are detailed. What nurses and psychiatric nurses will actually do in any given setting depends on: (i) the competence brought to the work as a consequence of basic or post-basic nursing education; (ii) the definition of mental illness and therefore of the work of 'mentally ill' patients; (iii) the extent of consensus around the question of whether each profession should or should not have only discrete, unique, circumscribed roles or whether there can be an overlap; and (iv) the cost of certain kinds of care, the difference in status and salary levels and the number of persons needed and available to provide certain kinds of care.

1413. PAUL, G. L. and LENTZ, R. J. **Psychosocial treatment of chronic mental patients. Milieu versus social learning programs.** Cambridge, Mass., & London, Harvard University Press, 1977, xiii, 528pp. £15.75

This book compares standard hospital care for chronic mental patients with milieu therapy and social-learning therapy. The authors find that both new approaches provide advances over traditional techniques. After a description of the design of the comparative project, sections deal with the organization and procedures used followed by a description of 4½ years work in the psychosocial units. There are sections making comparisons with hospital treatment and dealing with community follow-up after treatment in the psychosocial units. The book includes a bibliography (pp. 502-514).

1414. BARUCH, G. and TREACHER, A. **Treating the mentally ill.** *New Society*, London, 1978, April 20, vol. 44, no. 811, pp. 125-127.

The authors question how well psychiatric hospitals, or even the more recent general hospital psychiatric units, operate as diagnostic and therapeutic settings for the mentally ill. In recent years, psychotherapeutic methods have been introduced, although no formal training in psychotherapy is as yet given to psychiatrists. The traditional hospital attitudes and staffing structure mitigate against the patient and his family becoming actively involved in treatment. Radical changes are needed and the approach at Napsbury Hospital, where a team visits patients in their homes and admission is avoided where possible, could become a model for a possible reconstitution of the psychiatric services.

1415. MAGARO, P. A., GRIPP, R. and MCDOWELL, D. J. **The mental health industry: a cultural phenomenon.** New York, Wiley-Interscience, 1978, xiii, 272pp. £11.40

This book considers the underlying issues which prevent the evaluation of treatment of mental illness and attempts to place treatment within its cultural context to illustrate how concepts of pathology arise more out of cultural beliefs than from any scientific fact. Aspects considered are: (i) madness and culture; (ii) the historical treatment of madness in American instructions; (iii) treatment by control for behaviour modification; (iv) milieu therapy: democracy as treatment; (v) institutionalization; (vi) the mental health industry; (vii) the prescriptive treatment approach; and (viii) treatment as a capitalistic venture. A bibliography (pp. 227-259) covering each chapter individually is included together with an author and subject index.

1416. CAMPBELL, W. and MAWSON, D. **Violence in a psychiatric unit.** *Journal of Advanced Nursing*, Oxford, 1978, Jan., vol. 3, no. 1, pp. 55-64.

This paper discusses violence in the John Conolly Hospital in Birmingham and the features of hospital design and policy which seem to affect its incidence. Problems are caused architecturally by the delicate fabric of the unit. The open-plan design means that all the patients mix socially when not under treatment. There is a wide range of patients in terms of age, sex and diagnosis. Most cases of violence are 'characteristic' in that they are evoked and expected, and can be coped with. However, the open-plan approach seems highly unsuitable for a minority of acutely disturbed psychiatric patients, who would be more appropriately managed on a locked or lockable ward.

1417. SWEARINGEN, D. J. and THOMPSON, J. M. **What does the patient think? An evaluation of a general psychiatric ward.** *Hospital and Community Psychiatry*, Washington, 1978, March, vol. 29, no. 3, pp. 182-184.

A study, based on patients' opinions, was carried out on a general psychiatric ward at the Brentwood Veterans Administration Hospital, Los Angeles, in 1974, to determine the success of a new treatment scheme staffed largely by non-professional nursing assistants. The majority of patients said that their condition was improved on discharge and none said they were worse. They felt that the staff were understanding and helpful and that the atmosphere of the ward was peaceful and caring. Of the various treatments received, medication and individual counselling were judged to be the most useful.

Comparing the ward with 11 other psychiatric wards, it was found to have a shorter length of stay and cost less to run, but the readmission rates were similar. The study showed that a predominantly non-professional staff provided care that was both economical and satisfactory for the patients.

1418. SPIEGLER, M. D. and AGIGIAN, H. **The community training center: an educational-behavioural-social systems model for rehabilitating psychiatric patients.** New York, Brunner/Mazel, 1977, xx, 374pp.

This book considers an approach toward rehabilitating chronic psychiatric patients. The experience of the Community Training Center (CTC), Palo Alto, California, established eight years ago, has served as a model for 10 other psychiatric day treatment centres. The CTC uses the educational-behavioural-social systems model to help patients acquire the basic skills they need to live on their own. The three basic components of the model in action are: educational—which directly teaches social and living skills in specially designed classes; behavioural—which applies procedures such as a token economy and individual behavioural contacts to motivate people to learn and reduce maladaptive behaviour; and the social systems component which implements strategies for helping individuals cope with their home and work environments.

1419. ALASZEWSKI, A. **Problems in measuring and evaluating the quality of care in mental handicap hospitals.** *Health and Social Service Journal*, London, 1978, March 10, vol. 88, no. 4581, pp. A9-A15.

The history of procedures for assessing performance in National Health Service hospitals for the mentally handicapped is outlined. The author argues that assessment is concerned mainly with input of resources and very little with output, that is, with the quality of care provided and the organization of the patient's day. In a mental handicap hospital, quality of care must be measured in terms of the level of interaction between staff and patients. The author shows, by means of a study carried out in wards for patients with varying degrees of handicap, how a pattern of interaction can be used as an indicator of quality of care. A system of evaluating care by studying patient activities is also described and the author considers that these two indicators are interchangeable.

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American Journal of Clinical Pathology, East Washington Sq., Philadelphia, Pa. 19105, U.S.A. $4.00
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British Journal of Psychiatry, Headley Bros. Ltd., Ashford, Kent TN24 8HH, England. £4.50
British Medical Journal, British Medical Association, Tavistock Sq., London WC1H 9JR.
Canadian Medical Association Journal, P.O. Box 8650, Ottawa, Ont. K1G 0G8, Canada.
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